Maternal and Child Health Services
Title V Block Grant

State Narrative for North Carolina

Application for 2013
Annual Report for 2011

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications will be maintained on file in the Women's and Children's Health Section Office, located in Room C-7, 5601 Six Forks Road, Raleigh, NC

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Public input on the MCH Block Grant is obtained in several ways. It is posted on the Women's and Children's Health Section (WCHS) website in July and partnering agencies (including Healthy Start Foundation, March of Dimes state chapter, Area Health Education Centers, etc.) are asked to review it and provide feedback to the Section Office. While comments on the block grant application itself are minimal, ongoing communication with these agencies impacts policies and activities carried out by the WCHS. Another method for gaining public input on the application is sharing portions of the document with members of the Family Council and receiving their feedback. Ongoing public input is obtained throughout the year as WCHS staff members work with both state and non-governmental agencies to improve programs and services. Input from these consumer and professional stakeholders is included as much as possible in the relevant performance measure narratives in the grant application.

/2013/ As the Family Council has been transitioned into the new Branch-Family Partnership, public input on the MCH Block Grant was obtained from members of the new partnership who agreed to review the narrative and comment on it using an electronic survey. //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

In the 2010 MCH Needs Assessment, the WCHS Section Management Team decided to keep the same priority needs as identified in 2005, as these priority needs are very broad and continue to be true needs in the state. These priority needs are as follows:

1. Reduce infant mortality
2. Improve the health of women of childbearing age
3. Prevent child deaths
4. Eliminate vaccine-preventable diseases
5. Increase access to care for women, children, and families
6. Increase the number of newborns screened for genetic and hearing disorders and prevent birth defects
7. Improve the health of children with special needs
8. Improve healthy behaviors in women and children and among families
9. Promote healthy schools and students who are ready to learn
10. Provide timely and comprehensive early intervention services for children with special developmental needs and their families.

During FY12, the strengths and needs of the population of North Carolina have not shown a dramatic change. While gains have been made with decreases in infant mortality rates, child deaths, and teen pregnancies, much work remains to be done with respect to health disparities and improving systems of care.

Personnel changes which impact the Section's ability to affect these priorities have been cited in section III. D. Other MCH Capacity. The new staff members bring great strength and experience to their roles, so the impact should be positive. Efforts to improve capacity of the Section to achieve priority goals are described in Section B. Agency Capacity, as well as in the narratives for the national and state performance measures. Some of these efforts include the transition to Pregnancy Care Management and Care Coordination for Children and the implementation of the Bright Futures guidelines, the Innovative Approaches system grants, and the Maternal, Infant, and Early Childhood Home Visiting Program.

The WCHS conceives of priority-setting as a continuous process, in which useful data, both quantitative and qualitative, relevant to the broad mission of the Section are continuously being gathered and analyzed with an eye to adjusting the priorities and the activities of the Section as appropriate. In addition to these day-to-day "micro" analyses of relevant inputs, the Section utilizes formal needs assessment processes, such as the five year needs assessment process, to review and titrate Section priorities and activities. The newly formed Branch-Family Partnership in the C&Y Branch, which is described in Section III.B. Agency Capacity, will allow for ongoing feedback and involvement from families served by WCHS programs. Many WCHS staff members participated in the development of the Healthy North Carolina 2020 objectives, facilitated by the NC Institute of Medicine in partnership with the Division of Public Health and the State Center for Health Statistics. These measures will be tracked internally by Division staff. The Preconception Health Committee diligently reviews the Core Preconception Health Indicators each year, focusing their efforts on ten of the 45 indicators. During FY13, more formalized work on the upcoming 2015 Needs Assessment will begin as a work group comprised of staff members from all the branches will be formed.

Work on implementing the life course perspective in the daily work of Section staff members is ongoing. A conference entitled Improving the Health of Women, Children, and Families in NC: A Life Course Perspective was held in November 2011 to raise awareness about the life course perspective and to begin to think about developing a life course perspective metrics. About 150 section staff members attended the conference which featured a keynote presentation by Dr. Michael Lu. Following this conference, the SSDI Project Coordinator was charged by the Section Management Team with leading a Life Course Perspective Work Group comprised of section staff members from each of the five branches to determine appropriate next steps in using the life course perspective to add value to the work of the Section. The initial meeting of the work group was held in June 2012, so final action steps are not yet determined. In addition the SSDI Project Coordinator submitted a proposal to the Association of Maternal and Child Health Programs (AMCHP) on behalf of a North Carolina team comprised of Women's and Children's Health Section staff members and state and local partners to participate in the Life Course Metrics Project. North Carolina was selected to participate in this project along with six other states (Nebraska, Iowa, Massachusetts, Michigan, Louisiana, and Florida). It is anticipated that this metric will be used in the 2015 MCH Needs Assessment.

III. State Overview

A. Overview

In North Carolina (NC), governmental health and social services are generally administered through autonomous county-level governmental agencies. This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and regional level.

The NC Title V program is housed in the Women's and Children's Health Section (WCHS) within the NC Department of Health and Human Services (DHHS) in the Division of Public Health (DPH). The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

WCHS is responsible for overseeing the administration of the programs carried out with allotments under Title V. The mission of WCHS is to assure, promote and protect the health and development of families with emphasis on women, infants, children and youth. WCHS programs place a major emphasis on the provision of preventive health services beginning in the pre-pregnancy period and extending throughout childhood. The Section also administers several programs serving individuals who are developmentally disabled or chronically ill.

In FY03, the Section Management Team (SMT) held a retreat and defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. The WCHS Core Indicators are as follows:
1. Reduction of Infant Mortality
2. Improved Health of Women of Childbearing Age
3. Prevention of Child Deaths
4. Elimination of Vaccine-Preventable Diseases
5. Increased Access to Care for Women, Children, and Families
6. Prevention of Birth Defects
7. Improved Health of Children with Special Needs
8. Improved Healthy Behaviors in Women and Children and Among Families
9. Healthy Schools and Students who are Ready to Learn
10. All Newborns Screened for Genetic and Hearing Disorders
11. Provision of timely and comprehensive early intervention services for children with special developmental needs and their families.

The state of NC covers 52,175 square miles including 48,710 in land, and 3,465 in water. The 100 counties that compose the state stretch from the eastern coastal plains bordering the Atlantic Ocean, continue through the densely populated piedmont area, and climb the Appalachian Mountains in the west. These diverse geographical features pose a number of challenges to the provision of health care and other social services. In the sparsely populated western counties, there are vast areas of rugged terrain, which make travel difficult especially during the winter months and contribute to the isolation of the rural inhabitants. In the coastal plain counties, which cover almost a quarter of the State, swamp lands, sounds, and barrier islands also contribute to isolation and complicate transportation problems. Moreover, because most local health departments have maintained their single-county autonomy, rural departments are often under-funded and have difficulties attracting sufficient staff and operating efficiently. Although the state is becoming more urban, 64 of the 100 counties are still considered rural.

As of July 2008, NC maintained its position as the tenth most populous state in the nation with an estimated population of 9,222,414. This is an increase of more than three-quarters of a million

people in the past 5 years, a 9.6% increase. Data from the 2000 Census indicate that more than one out of every four individuals in the state is a member of a minority group. African Americans are the largest minority (21.4% of the population), while the combined minorities -- Hispanics (4.7%), Native Americans (1.2%) and Asian/Pacific Islanders (1.4%) -- represent a much smaller percentage. Corresponding percentages for the United States are 68.9% white, 12.9% African American, 12.5% Hispanic, 0.8% Native American, and 2.9% Asian/Pacific Islander. NC is one of seven states in the nation in which African Americans make up over 20% of the population. In addition, NC has the eighth largest Native American population in the United States. There are eight tribes that are recognized by the state; however, only the Federal Government recognizes the Eastern Band of Cherokees.

Because of the importance of agriculture in NC, many seasonal and migrant farm workers are employed in the state. Estimates of these individuals vary depending on the source of data. The Employment Security Commission estimates that there were 37,315 migrants and 24,365 seasonal workers in the state in 2007. Analysis of employment security data indicates that the number of migrant workers and seasonal farm workers has decreased steadily since 2004. Of migrant workers, 98% are Spanish-speaking.

According to US Census data, in 1990, there were 76,726 persons of Hispanic/Latino origin in NC, but by 2000, the number had grown to 378,963 persons -- almost a five-fold increase. By 2007, the US Census Bureau reported that NC had 638,444 persons of Hispanic and Latino ethnicity, a 56 percent increase since 2000. This estimate amounts to just over 7% of the total population in NC in 2007, compared to a national rate of almost 15%. As North Carolina's Hispanic population is disproportionately young and most of the female Hispanic newcomers are in their peak childbearing years, the potential for continued growth of the state's Hispanic population is great. Seventy-one percent of North Carolina's 2007 Hispanic population is under age 35 whereas only 46 percent of the state's non-Hispanic population is in this age range. According to the United States Census Bureau's 2005--2007 American Community Survey, the median age of the state's Hispanic population was 25.6 years, compared to 40.1 years for the white non-Hispanic population of the state. Given the younger age distribution of the Hispanic population, there are unique health issues for this group.

Although the recent downturn in the economy and the post September 11 restrictions on immigration may have slowed down the Hispanic/Latino migration to the state, the relative youth of the population, their high fertility and birth rates, and the increasing numbers of seasonal workers choosing to settle down, indicate continuing significant growth in this population. Their impact on the public health system, particularly on maternal health and family planning programs, will be even more significant in the near future. In the last five years, the number of Hispanic/Latino patients as a proportion of the total family planning patients of the Statewide Family Planning Program has risen to 21%. Similarly in 2008, the proportion of Hispanic/Latino prenatal patients in local maternity clinics was 21.3%. In addition, NC Hispanic births have increased from 2% of the state's births in the early 1990s to 17% in 2007. According to US Census data, of all the states, North Carolina had the second highest percentage increase in Hispanic population between July 1, 2007 and July 1, 2008 at 7.4%. Only South Carolina's increase was higher at 7.7%.

B. Agency Capacity

WCHS is comprised of five Branches: Children & Youth (C&Y Branch), Early Intervention (EI), Immunization, Nutrition Services (including Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]), and Women's Health. The Section Management Team, which is comprised of the Chief, Section Operations Manager, and the five Branch Heads, meets weekly to facilitate joint planning, to keep key staff informed of current activities and issues, and to plan short and long term strategies for addressing current issues. A similar process occurs within the Branches which are responsible for assessing and responding to the needs of its target population(s).

The public health system in North Carolina is not state administered, but there are general statutes in place for assuring that a wide array of maternal and child health programs and services are available and accessible to North Carolina residents. State statutes relevant to Title V program authority are established for several programs administered by WCHS. These statutes include (not an exhaustive list):

GS130A-4.1. This statute requires the NCDHHS to ensure that LHDs do not reduce county appropriations for local maternal and child health services because they have received State appropriations and requires that income earned by LHDs for maternal and child health programs that are supported in whole or in part from State or federal funds received from NCDHHS must be used to further the objectives of the program that generated the income.

GS130A-124. This statute requires NCDHHS to establish and administer the statewide maternal and child health program for the delivery of preventive, diagnostic, therapeutic and habilitative health services to women of childbearing years, children and other persons who require these services. The statute also establishes how refunds received by the Children's Special Health Services Program will be administered.

GS130A-125. This statute requires NCDHHS to establish and administer a Newborn Screening Program which shall include, but not be limited to, the following: 1) development and distribution of educational materials regarding the availability and benefits of newborn screening, 2) provision of laboratory testing, 3) development of follow-up protocols to assure early treatment for identified children, and provision of genetic counseling and support services for the families of identified children, 4) provision of necessary dietary treatment products or medications for identified children as indicated and when not otherwise available, and 5) for each newborn, provision of screening in each ear for the presence of permanent hearing loss.

GS130A-127. This statute requires NCDHHS to establish and administer a perinatal health care program. The program may include, but shall not be limited to, the following: 1) prenatal health care services including education and identification of high-risk pregnancies, 2) prenatal, delivery and newborn health care provided at hospitals participating at levels of complexity, and 3) regionalized perinatal health care including a plan for effective consultation, referral and transportation among hospitals, health departments, schools and other relevant community resources for mothers and infants at high risk for mortality and morbidity.

GS130A-129-130. These statutes require NCDHHS to establish and administer a Sickle Cell Program. They require that LHD provide sickle cell syndrome testing and counseling at no cost to persons requesting these services and that results of these tests will be shared among the LHD, the State Laboratory, and Sickle Cell Program contracting agencies which have been requested to provide sickle cell services to that person. In addition, these statutes establish the Council on Sickle Cell Syndrome, describing its role and the appointments, compensation, and term limits of the council members.

GS130A-131.8-9 These statutes establish rules regarding the reporting, examination, and testing of blood lead levels in children. Statutes 131.9A-9G include requirements regarding the following aspects of lead poisoning hazards: 1) investigation, 2) notification, 3) abatement and remediation, 4) compliance with maintenance standard, 5) certificate of evidence of compliance, 6) discrimination in financing, 7) resident responsibilities, and 8) application fees for certificates of compliance.

GS130A-131.15. This statute requires NCDHHS to establish and administer an Adolescent Pregnancy Prevention Program. The statute describes the management and funding of the program including the application process, proposal requirements, operating standards, criteria for project selection, schedule of funding, and funding limitations and levels.

GS130A-131.16-17. These statutes establish the Birth Defects Monitoring Program within the State Center for Health Statistics. The program is required to compile, tabulate, and publish information related to the incidence and prevention of birth defects. The statutes require physicians and licensed medical facilities to permit program staff to review medical records that pertain to a diagnosed or suspected birth defect, including the records of the mother.

GS130A-152-157. These statutes establish how immunizations are to be administered, immunization requirements for schools, child care facilities, and colleges/universities, and when and how medical and religious exemptions may be granted.

GS130A-371-374. These statutes establish the State Center for Health Statistics within NC DHHS and authorize the Center to 1)collect, maintain and analyze health data, and 2) undertake and support research, demonstrations and evaluations respecting new or improved methods for obtaining data. Requirements for data security are also found in the statutes.

GS130A-422-434. These statutes establish the Childhood Vaccine-Related Injury Compensation Program, explain the Program requirements, and establish the Child Vaccine Injury Compensation Fund.

GS130A-440-443. These statutes require health assessments for every child in this State entering kindergarten in the public schools and establish guidelines for how the assessment is to be conducted and reported. Guidelines for religious exemptions are also included.

Using federal Title V funds and other funding sources, WCHS must contract with local health departments (LHDs) and other community agencies to assure that these services are available. There are 85 LHD clinics which provide clinic and preventive services in all 100 counties. In addition, there are many community health centers and other agencies providing services. Each contract contains a scope of work or agreement addenda that specifies the standards of the services to be provided. The public health departments, which have local autonomy, have a long-standing commitment to the provision of multidisciplinary perinatal, child health, and family planning services, including medical prenatal care, case management, health education, nutrition counseling, psychosocial assessment and counseling, postpartum services, child service coordination, well-child care, and primary care services for children.

A wide range of preventive health services are offered in virtually all LHDs, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of WCHS supported prenatal and postpartum services are based on the American College of Obstetrics and Gynecology (ACOG) guidelines. These standards have been revised to be consistent with best practices derived from the current scientific literature as well as with the relevant NC regulations and are provided in soon to be published Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care. Because of this consistency with these nationally recognized guidelines, there is a good case to be made that these standards should also provide the basis for standards for the prenatal care provided by Medicaid managed care and ultimately commercial managed care agencies. Local health agencies receiving Title X funding to provide family planning services must abide by the January 2001 Program Guidelines for Project Grants for Family Planning Services and the subsequent Title X Program Instruction Series developed by the Office of Population Affairs (OPA), US DHHS.

Consultation and technical assistance for all contractors is available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes regional child health and women's health nursing and social work consultants who routinely work with agencies within assigned regions.

Additional Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

High Risk Maternity Clinics (HRMCs) - In order to achieve the WCHS goal of risk-appropriate prenatal care, the Section also supports HRMCs across the state. Eleven HRMCs are housed in larger health departments, and are generally staffed by local obstetricians. They do not draw from a regional catchment area and refer the highest risk clients to the tertiary centers for care. At the time of the inception of the HRMC program, the LHD HRMCs were pioneers in the provision of multidisciplinary care and also filled in some gaps where intermediate level care was somewhat inaccessible. As time has passed, the multidisciplinary care model they pioneered has been widely adopted, at least in the public sector, and the tertiary center network in the State has matured. The future role of these "intermediate level" HRMCs is unclear. As part of its charge to provide technical assistance and oversight to this network of clinics, WCHS continues to assess what changes are needed in the program to achieve the goal of risk-appropriate services for all pregnant women.

/2012/ Pregnancy Medical Home (PMH) and Pregnancy Care Management (PCM) -- WCHS is working in partnership with the Division of Medical Assistance (DMA) and Community Care of North Carolina (CCNC) and other community stakeholders including providers and LHDs to implement a new statewide program that creates a system of care through the use of a medical home concept for OB care (PMH) and the provision of PCM services to pregnant Medicaid recipients with risk factors for poor birth outcome. The goal is to improve the quality of care given to Medicaid recipients, thereby improving birth outcomes and reducing Medicaid costs. CCNC has seen success in similar efforts in primary care, and this model builds on prior successes, as well as integrating new aspects relative to the unique needs of the obstetric population and the strengths of a public health approach. If a pregnant Medicaid recipient's aid program category covers pregnancy services, she is eligible to participate in this program.

To qualify for participation as a PMH, the provider must agree to the following: ensuring that no elective deliveries are performed before 39 weeks of gestation; engaging fully in the 17P project; decreasing the cesarean section rate among nulliparous women; completing a high-risk screening on each pregnant Medicaid recipient in the program and integrating the plan of care with the local pregnancy care manager; and open chart audits. In exchange for meeting the program expectations the PMH will receive the following incentives: exemption from prior approval on ultrasounds; $50 for completing a high risk screening tool at initial visit; $150 incentive for the postpartum visit per Medicaid recipient; and increased rate for a vaginal delivery. Any provider who bills global, package or individual pregnancy procedures is eligible to participate in this program as long as he/she agrees to the program requirements.

Pregnancy care managers are employed by the local health department and work as members of the prenatal care team, collaborating closely with prenatal care providers to support the patient in achieving an optimal pregnancy and birth outcome. PCM services are provided by a nurse, social worker, or human services professional. Care managers coordinate patient care and needed services, to address the patient's medical and psychosocial concerns during pregnancy and postpartum. WCHS also administers a limited amount of state appropriations, which categorically support the provision of pregnancy care management services for pregnant women who are ineligible for Medicaid. LHDs are free to allocate portions of the block granted federal and state funds they receive to provide PCM or other support services to patients ineligible for Medicaid. //2012//

Minority Infant Mortality Reduction Efforts - The Healthy Beginnings (Minority Infant Mortality Reduction) Program was established in 1994 to provide funding to community-based organizations that developed programs to reduce infant mortality and low birth weight births among minority populations in North Carolina. In an order to strengthen community-based efforts to address perinatal health disparities, and thereby improve birth outcomes among communities of color, the Targeted Infant Mortality Reduction (TIMR) program has merged with the Healthy Beginnings Program. Community based organizations and LHDs with experience working in minority communities are eligible to apply for Healthy Beginnings funding. Funding is available

for 3 years, contingent upon performance. Between 10 and 14 sites are funded at an award level of $75,000 to $100,000 annually. Grant recipients are expected to implement programs that will impact the reduction of minority infant mortality and low birth weight births in their communities and thereby improve minority birth outcomes. Funded agencies are expected to provide the following to minority pregnant women (or women within the 60 day post partum period):
-Case management/care coordination;
-Health education and support which includes education in the following areas: breastfeeding initiation and maintenance up to at least 6 weeks, eliminating use and exposure to tobacco, safe sleep, folic acid consumption, reproductive life planning, healthy weight and exercise;
-Ensure well child visits and proper immunizations for their babies;
-Outreach; and
-Work with their male partners when applicable.

Baby Love Plus - The NC Baby Love Plus Program serves African American and Native American pregnant women enrolled in the Baby Love Maternity Care Coordination Program and receiving care at a project area LHD or pre-determined clinic. The NC Baby Love Plus program is one of the federally funded Healthy Start infant mortality reduction projects designed to focus on eliminating racial disparities. While each of the programs is designed to serve a specific geographic region (Northeastern, Triad, or Eastern counties), they collectively serve pregnant and parenting families through the following core components: outreach, case management, interconceptional care, depression screening, strengthening perinatal systems of care, and local consortium development. The Northeastern Project also has a focus on the prevention of family violence during and around the time of pregnancy.

The NC Baby Love Plus Program partners with the LHDs for implementation of the program. LHD staff members carry out the outreach and case management efforts. Local staff includes Community Health Advocates and Family Care Coordinators. Approximately 120,000 women are served through this program. Baby Love Plus also subcontracts with community and faith-based organizations that provide support services and education to women of childbearing age (15-44 years), infants, fathers/male partners, and families in areas including health promotion, healthy life styles, parenting, safe sleep practices, and fatherhood development.

Teen Pregnancy -- In addition to family planning services for all women of childbearing ages, the Family Planning and Reproductive Health Unit (FPRHU) also manages the Teen Pregnancy Prevention Initiative (TPPI). The initiative, which was funded with state appropriation beginning in 1989, initially supported programs designed to prevent first pregnancies among high-risk youth in specifically targeted communities. A unique component of this program is a legislatively mandated requirement for funded programs to conduct outcome evaluations. Over time, results of the evaluations have enabled TPPI staff not only to identify "best practice" models in primary pregnancy prevention, but also be more prescriptive in their guidance to prospective and currently funded programs. In the FY11 application cycle, TPPI staff prescribed 9 best practice models. Applicants are strongly encouraged, though not required, to use the prescribed models. However, all TPPI projects are required to participate in an ongoing evaluation using a web-based system administered by the state Office of Information Technology Services.

The second major component of the TPPI program is a secondary prevention model initially implemented by the NC Division of Social Services (DSS) in 1984, eventually transferred to DPH in 1998 and then subsumed under the TPPI umbrella. While the primary focus of the Adolescent Parenting Program (APP) is in reducing subsequent unintended pregnancies among pregnant/parenting teens, it is also focused on promoting parenting skills, preventing child abuse and neglect, and ensuring high school graduation among its participants.

In FY10, the FPRHU funded 53 TPPI projects in 28 secondary prevention and 25 primary prevention sites in 38 North Carolina counties. The FPRHU contracts with a variety of agencies including not-for-profit community based and faith-based organizations, as well as LHDs and schools, to implement activities and strategies to reduce unintended teen pregnancies. Although

the programs predominantly serve at risk adolescent females ages 10-18, several funded projects focus on males.

In response to the rapidly growing Latino population in the State, the TPPI program continues to seek additional funding to support Latino teen pregnancy prevention initiatives. In FY06, the TPPI program implemented an Annie E. Casey initiative Plain Talk (Hablando Claro), a neighborhood-based initiative aimed at helping adults, parents and community leaders develop the skills and tools they need to communicate effectively with young people about reducing adolescent sexual risk-taking. Additionally, ¡Cuidate! (Take Care of Yourself), a primary prevention model aimed at reducing sexual risk among Latino youth, is among the science-based best practice models recommended by TPPI for the FY11 funding cycle. TPPI is able to address ethnic and racial disparities by collaborating with private foundations, federal grantees agencies, local government, and local Latino advocacy groups to support initiatives that address the reduction of unintended teen pregnancies among Latino teens.

/2012/Project Connect - This is funded by the Office of Adolescent Health for $1.7 million annually from 9/2010 to 8/2013. The project offers support to pregnant and/or parenting women ages 13-24 in five counties with health maintenance, parenting skills and parental self-sufficiency.//2012//

Additional Preventive and Primary Care Services for Children

WCHS provides preventive health services to children from birth to 21 years of age primarily through LHD clinics. The schedule of recommended visits is based on Bright Futures guidelines. Normally, clinic services are not provided for acutely ill children, although some health departments do provide pediatric primary care. Nurse screening clinics are conducted by public health nurses in LHDs. Physicians do not staff these clinics; however, services are provided under the guidance of the physician who attends the pediatric supervisory clinic. Medical management includes written policies and procedures that are updated regularly. Public Health Nurse Screeners receive specialized training for this role through a training program sponsored by the C&Y Branch. Nurse screening clinic services include: parental counseling regarding good health, nutrition practices and developmental milestones; immunizations; assessment of proper growth, development, hearing, vision, and speech; screening for anemia and lead; and referrals as needed. Pediatric clinics are conducted by physicians (family practitioners and/or pediatricians), nurse practitioners, and/or physician assistants. They serve as referral clinics for children with problems identified in nurse screening clinics. Pediatric clinic staff make referral for specialty consultations as needed.

The purpose of the Health Check (HC) program is to facilitate regular preventive medical care and the diagnosis and treatment of any health problem found during a screening for children eligible for Medicaid and under the age of 21. Health Check Coordinators (HCC) play a vital role in outreach efforts and assuring that Medicaid recipients access preventive health screenings. The HCC use an Automated Information and Notification System (AINS) to track and follow Medicaid eligible children. This system has the ability to generate personalized reminder and missed appointment letters based on paid claims data. The HCC make direct contact with clients via telephone calls, additional personalized letters, and occasional home visits. The type and results of their contacts are recorded in the comment section of the database. They work closely with the managed care representatives at local departments of social services to ensure children are connected with their primary care provider for continuity of care. In addition, they work closely with the provider community to ensure children receive regular preventive health care and follow-up for conditions that have been referred to a specialist.

NC Health Choice for Children (NCHC), the child health insurance program in NC, is a federal and state partnership to provide comprehensive health insurance to uninsured children. It provides free or low cost health insurance to children whose families cannot pay for private insurance and who do not qualify for HC. Children with special health care needs are eligible to receive additional benefits under NCHC. This program is administered jointly by DMA and DPH,

with DMA providing oversight for the program and establishing eligibility policy and DPH being responsible for outreach efforts and for services to children with special health care needs. Outreach to potentially eligible families is coordinated by Outreach Coalitions in each county. WCHS supports the efforts of the local coalitions by providing tools such as print materials, electronic media pieces, monthly coalition updates, consultation and technical assistance, workshops, and outreach to state and regional organizations.

Session Law 2005-276 by the NC General Assembly (NCGA) mandated the NCHC program to limit participation to eligible children ages 6 through 18 beginning January 1, 2006. This session law also mandated the Medicaid program to provide coverage for children birth through the age of five with family incomes equal to or less than 200 percent of the federal poverty level beginning January 1, 2006. As a result of this legislation, current NCHC children ages birth through five were moved to the HC program on January 1, 2006. In addition, the NCGA capped NCHC enrollment growth to 3% every 6 months and reduced NCHC reimbursement rates to 115% of the HC fee schedule on 1/1/2006 and 100% on 7/1/2006. The NCGA also directed DHHS to move NCHC children (ages 6 through 18) into the Community Care of NC networks for case management services. WCHS worked closely with DMA to assure a smooth transition for NCHC children to Health Check. This involved drafting notices/letters to families and preparing a bulletin/list serve notices for providers to prepare for transition issues related to prior approval, hospital coverage, etc.

School Health Matrix Team - The School Health Matrix Team was created in FY04 to enhance the effectiveness of DPH programs that target the school age population, and/or focus on services available in or for schools. The DPH Matrix Team works in close collaboration with the Department of Public Instruction (DPI) to improve the health and academic achievement of students by supporting the development of and strengthening school health programs and policies across the state. The Matrix Team allows the DPH to effectively utilize staff across Branch and Section lines to create a multi-disciplinary, multi-agency focus on school health. The Section Chiefs for Oral Health, WCH, and Chronic Disease and Injury provide overall guidance in program planning, marketing, and implementation of services and to help build capacity for school health services.

Early Childhood Comprehensive System - In 2004 the Division of Public Health obtained the support of NC DHHS Secretary for use of the State Early Childhood Comprehensive Systems (ECCS) grant as a core vehicle for increasing coordination and collaboration within and outside the department with respect to early childhood issues. NC's ECCS Implementation Plan was created by a multi-agency state-level partnership that met throughout the ECCS planning period and agreed to develop a plan for a comprehensive, integrated early childhood system that supports school readiness and builds on existing efforts and initiatives.

The vision for the ECCS Plan was intentionally created to be consistent with the visions of established early childhood partners, e.g., the NC Partnership for Children (Smart Start), NC's SPARK initiative (funded by the Kellogg Foundation), so that it could serve as a bridge rather than a barrier in system-building efforts. As stakeholders focused on the fact that there are multiple and interacting factors affecting child outcomes, the need for engagement across systems (health, early care and education, families, etc.) became a primary objective of the planning process.

The goals of the ECCS Plan are:
1.Share accountability for an effective, comprehensive, and integrated early childhood system in NC in a multi-agency state-level partnership.
2.Use a set of shared indicators for school readiness to evaluate success at all levels of the early childhood system.
3.Develop a shared early childhood data system.
4.Infuse the early childhood system with people who have core competencies in early childhood (based in developmental science) as well as the practical approaches and community

relationships necessary to provide effective services to children and families.
5.Foster a philanthropic and government consortium to nurture and build state and local partnerships.
6.Secure the commitment of families, stakeholders, and decision makers about the costs, benefits, and consequences of building or neglecting a comprehensive, integrated early childhood system.
7.Improve our systems of care by using evidence-based practices to positively affect child outcomes for all critical components of a comprehensive early childhood system.

North Carolina's ECCS Plan was created during the planning phase (9/1/03 -- 8/31/05) of the ECCS grant. During the first four years of the implementation phase (9/1/05 -- 05/31/09), stakeholders were successful in implementing a number of strategies outlined in the original ECCS plan. In the current phase of the grant program (6/09 -- 5/10), ECCS grant resources are focused on further development of a comprehensive leadership structure that that shares accountability for an effective system and for child outcomes. Governor Beverly Purdue is taking steps to create an Early Childhood Advisory Council as required in the Head Start Reauthorization Act of 2007. The ECCS Grant Coordinator is serving on the Early Childhood Advisory Council Work Group to support efforts to develop the Council.

/2012/ Maternal, Infant and Early Childhood Home Visiting Program -- WCHS has awarded five community grants as part of this program. Applications were limited to those from counties or areas determined to be "high need," based on factors including premature birth rates, infant mortality rates, poverty and crime, domestic violence, high school dropout rates, substance abuse, unemployment and child maltreatment. Home visiting programs may provide a variety of social, health-related, or educational support and are offered on a voluntary basis to pregnant women or young children. Community grant recipients include the Center for Child and Family Health (Durham); the Gaston County Health Department; the Buncombe County Department of Health; the Toe River Health Department (Mitchell and Yancey Counties); and the Northampton County Health Department (serving Northampton, Halifax, Edgecombe, and Hertford Counties). The N.C. Early Childhood Advisory Council (ECAC), created by Governor Perdue in 2010, will be the state advisory group for the grant program. In addition to DPH, the State Home Visiting program also will be linked with various state-level early childhood initiatives housed within the Department of Health and Human Services, including the Division of Social Services, Division of Child Development, Division of Mental Health/Developmental Disabilities/Substance Abuse Services. Other key stakeholders include the NC Head Start Collaborative Office and the NC Partnership for Children. The first year of the community grants will begin in fall 2011 and end in September 2012 with the option to renew for two years, pending the availability of federal funds. //2012//

Services for Children with Special Health Care Needs (CSHCN)

/2013/ The C&Y Branch has lead responsibility for CSHCN from birth to 21 years and works closely with the EI Branch that provides services to the birth to three year old population of children with developmental disabilities. There is a strong Branch-Family Partnership (BFP) and a staff position for a parent of a child with special needs employed to provide guidance and direction for family/provider interaction, collaboration and input for services. //2013//

Children's Special Health Services (CSHS) is a state-administered program, financed by both federal and state funds. Care is provided through a network of professionals in the private section, clinics, hospitals, schools, and community agencies. All aspects of patient care are addressed, including assessment, treatment, and follow-up. CSHS provides cardiology, neurology, neuromuscular, oral-facial, orthopedic, myelodysplasia, speech/language and hearing services. In addition to providing diagnostic and treatment services through CSHS-sponsored clinics, the program also reimburses limited services for eligible children on a fee-for-service basis. Covered services include hospitalization, surgery, physicians' care, laboratory tests,

physical, occupational and speech therapy, medication, durable medical equipment, orthotics and prosthetics, medical supplies and other interventions. In addition to specialty clinic services, selected "wrap-around" services are funded for Medicaid-eligible children on a fee-for-service basis. CSHS is reimbursed by Medicaid for provision of most of these services, which include hospitalization; physicians' care; laboratory tests; physical, occupational and speech therapy; medication; durable medical equipment; orthotics and prosthetics; medical supplies; and other interventions.

The WCHS continues to be committed and guided by the key principles of comprehensive, community based, coordinated and family-centered care. There have been dramatic changes at the state and community level among key collaborators such as Early Intervention, Mental Health/Substance Abuse/Developmental Disability, School Health, and the private and public health care financing and delivery system, as well as significant shifts in priorities and resource allocation in DPH. In response, the CSHCN program has continued to review and critically evaluate all aspects of the program. The process has been directed by key personnel within CSHCN, in conjunction with a strengthened Family Council, the Commission for CSHCN, and other representatives from key constituency groups. Driven by considerations to improve the efficiency and effectiveness of services, while concurrently developing strategies reflective of a family-centered approach, the CSHCN program is being reorganized both centrally and regionally in WCHS, as well as in relation to community partners. The early evidence is that this will result in improved collaboration and coordination. Of equal importance, the objective to better integrate services and supports for children with special health care needs into all aspects of C&Y Branch initiatives is being strongly pursued.

/2012/ Care Coordination for Children - As of March 1, 2011, the Child Service Coordination Program, which was billed as targeted case management fee for service, has changed to a new population care management service called Care Coordination for Children (CC4C). The new CC4C program is a collaborative effort at the state level between DPH and DMA, as well as Community Care of North Carolina. The CC4C care management services will be provided by local health department staff, who will work collaboratively with the local Community Care network staff as well as the Medical Homes in the community. The CC4C target population is children birth to 5 years of age in each county who: 1) have special health care needs, 2) are exposed to highly stressful situations, 3) are in foster care and not linked to a Medical Home, 4) are transitioning out of a Neonatal Intensive Care Unit back to the community and a medical home; and 5) who are high cost / high users of services. The program goals are to maximize health outcomes while controlling costs in a managed care setting, which will be measured by monitoring nine data points. CC4C services are provided based on patient need and according to risk stratification guidelines. The amount of contacts is determined by the patient's individual needs and plan of care, in order to effectively meet desired outcomes. Contacts may occur in various settings including the health care provider office, community, or patient's home, as well as by phone.//2012//

Newborn Screening Services - The universal newborn metabolic screening services were initiated in North Carolina in 1966 with services for phenylketonuria. Tandem mass spectrometry was begun in July 1977 and as of 2009, North Carolina screens for all of the nationally recommended conditions with the addition of Biotinidase deficiency. The newborn metabolic screening samples and newborn hearing screening results are obtained simultaneously at birthing hospitals in North Carolina and reported through the same screening form. Follow-up is conducted on all newborns with a confirmed condition.

Neonatal Hearing Screening - Hearing screening has been mandatory for all infants born in NC as of October 1, 1999. Screening equipment was provided to 60 birthing hospitals through a special project of WCHS. The tests are performed quickly while babies are asleep. Audiologists affiliated with C&Y Branch Speech and Hearing Teams provide technical assistance to the hospitals and also perform infant hearing screenings and diagnostic assessments for older children.

The School Based Child and Family Support Team Initiative was begun during FY06. Its mission is to provide appropriate family-centered, strengths-based community services and supports to those children at risk of school failure or out-of-home placements as a result of the physical, social, legal, emotional, and developmental factors that affect their academic performance. While the staff person for the Initiative reports directly to the Secretary of DHHS, he is housed in the C&Y Branch and collaborates with branch members on this project. Through the Initiative, all State and local child serving agencies will collaborate and communicate to share responsibility and accountability to improve outcomes for at-risk children and their families. In 100 schools located in 21 Local Education Agencies across the State, Child and Family Support Team Leaders (a school nurse and social worker team in each school) will identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, legal, emotional, and developmental factors that affect their academic performance. These services are necessary so that those at-risk children may succeed academically, live in safe, nurturing and permanent families, and have opportunities for healthier and more stable lives.

/2013/ The Family Council for CYSHCN has been expanded and further integrated into the C&Y Branch. The new Branch-Family Partnership includes members of the previous Family Council but further integrates family representatives from across the Branch such as Early Hearing Detection and Intervention (EHDI), Newborn Screening, Innovative Approaches (IA) and School Health family representatives. At a kick-off celebration in March 2012, staff and families discussed the expanded effort and identified mutual areas of interest. Through an interest inventory completed by family representatives, staff have a direct and efficient path to receiving family input into their programs. Family members completed a grid of services, priorities, and outstanding issues to indicate areas where they would like to be involved in planning, review, implementation, training or evaluation. Families will interact directly with staff delivering service in their areas of interest. This type of outreach collaboration with families will be ongoing to assure continued expansion of family involvement. The Branch has doubled the funding in a contract that supports reimbursement for families to assure they are adequately compensated for their involvement. The BFP and the BFP Steering Committee is staffed by the Family Liaison Specialist who will coordinate and assure continued positive progress.

There are specific partnerships and collaborations that occur around CYSCHN including case management, CSHCN call line, IA grants, early mental health grant (LAUNCH), school nurses, the legislative Commission on CSHCN, Office on Disability and Health, and newborn screening programs. The WCHS has made strides to involve families meaningfully in policy, planning, evaluation, and educational activities directed toward children birth to 21 years of age.

IA is an initiative of the C&Y Branch that intends to improve the health of CYSHCN through the improvement of local systems of care that will be family centered, coordinated, and sustainable. Rather than create a program, the initiative is intended to create local teams to identify gaps and duplication in the system of services provided to CSHCN and their families and provide a coordinated/family centered approach to care that improves the health and wellbeing of CSHCN. The approach developed is anticipated to be an adjunct to existing programs and services. Anticipated outcomes include increased satisfaction among the youth and families involved in the initiative (when compared to previous approaches and to other approaches) and improved outcomes for youth with special health care needs.

In the past, the C&Y Branch funded a number of parenting programs that were evidence based, but only reached a small number of families. After several years of consideration the funds are being refocused on the Triple P program, an evidence-based population health initiative reaching large numbers of children with mild to severe behavioral health

difficulties. The program is provided at multiple levels of intervention intensity using a variety of delivery formats. //2013//

C. Organizational Structure

DHHS is a cabinet-level agency created in October 1997 when the health divisions of the Department of Environment, Health and Natural Resources (DEHNR) were combined with the existing Department of Human Resources (DHR). Lanier M. Cansler was appointed as Secretary of DHHS by Governor Beverly Perdue in January 2009. Serving as State Health Director and Division Director for DPH since March 2009 is Dr. Jeff Engel. Dr. Engel served as the State Epidemiologist beginning in 2002. In 2006, he was named Chief of the Epidemiology Section of the Division.

The Department is divided into 32 divisions and offices which fall under four broad service areas -- health, human services, administrative, and support functions. Divisions and offices include: Aging and Adult Services; Budget and Analysis; Child Development; Citizen Services; Controller; Council on Developmental Disabilities; Economic Opportunity; Education Services; Environmental Health; General Counsel; Government Relations; Health Service Regulation; Human Resources; Information Resource Management; Internal Audit; Medicaid Management Information Systems; Medical Assistance; Mental Health, Developmental Disabilities, and Substance Abuse Services; Privacy and Security Office; Procurement and Contract Services; Property and Construction; Public Affairs; Public Health, Rural Health and Community Care; Secretary's Office; Services for the Blind; Services for the Deaf and Hard of Hearing; Social Services; State Center for Health Statistics; State Operated Healthcare Facilities; Vital Records; and Vocational Rehabilitation. DHHS also oversees 18 facilities: developmental disability centers, psychiatric hospitals, neuromedical treatment centers, alcohol and drug abuse treatment centers, schools for the deaf and blind, and early intervention programs.

DPH is comprised of the Director's Office and ten other offices and sections: Administrative, Local, and Community Support; Chronic Disease and Injury; Epidemiology; Human Resources; Office of Minority Health and Health Disparities; Oral Health; State Center for Health Statistics; State Laboratory of Public Health; Vital Records; and WCHS.

Kevin Ryan, Section Chief, is the Title V Program Director and Carol Tant, Children and Youth Branch Head, is the CSHCN Program Director. WCHS is responsible for overseeing the administration of the programs carried out with allotments under Title V and for other programs including family planning, early intervention, nutrition services (including the state WIC program), and immunization. WCHS has a history of sound management practices and oversight involving grants and contractual funds. It administers hundreds of grants and contracts each year in a capable and professional manner. WCHS uses a sub-recipient monitoring system established by DPH. This system rates each contractor's performance, and includes corrective action protocols for low performing contractors. Such contractors receive additional monitoring and site visits in order to develop and implement an improvement plan. To date, no deficiencies have been noted in any internal or external audit, review or report on the Division's financial management system.

/2013/ Effective on February 1, 2012, Governor Bev Perdue appointed Al Delia to serve as Acting Secretary of the NC DHHS. Before joining DHHS, Delia was a member of the Governor's senior staff beginning as Policy Director in 2009. Delia was elevated to Senior Advisor later that same year. From 2006-2009 Secretary Delia was president and CEO of North Carolina's Eastern Region Development Commission (NCER) in Kinston, NC. He oversaw business recruitment, retention, expansion and creation in a 13-county region. Prior to his work at NCER, Delia worked in North Carolina's University System, first as Director of the East Carolina University eastern regional office of the Small Business and Technology Development Center (SBTDC), then as Associate State Director of the SBTDC at UNC-Chapel Hill.

Also effective on February 1, 2012, Dr. Laura Gerald, former head of the Health and Wellness Trust Fund, became the new state health director. She also led Governor Perdue's Eugenics Compensation Task Force.//2013//

Organizational charts for DHHS and DPH are attached.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The Section oversees and administers an annual budget of over $528 million and employs 1,166 people. This is 55% of the DPH staff, along with 68% of the budget. The WCHS's broad scope promotes collaborative efforts while discouraging categorical approaches to the complex challenge of promoting maternal and child health. The Section is committed to ensuring that services provided to families are easily accessible, user-friendly, culturally appropriate, and free from systemic barriers that impede utilization. While many staff members work in the central office in Raleigh, there are a number of regional consultants who work from home-based offices. In addition, the Early Intervention Branch has a network of 18 Children's Developmental Services Agencies (CDSAs) serving all 100 counties.

Key Staff Members

Section Chief - Dr. Kevin Ryan became the Title V Director in March 1999. He had served as Chief of the Women's Health Section (now Women's Health Branch) since 1991. Dr. Ryan graduated from the University of California at Davis Medical School and completed a residency in Obstetrics and Gynecology at the University of Arizona Health Sciences Center in Tucson, Arizona. After completing his residency in 1986, he became an Assistant Professor in the Department of Obstetrics and Gynecology and then began a private practice in obstetrics and gynecology. He completed an MPH from the UNC School of Public Health, Department of Maternal and Child Health in 1991. Since his graduation he has maintained an active relationship with the Department, and has served as Adjunct Assistant and then Associate Professor.

Section Business Operations Manager - Peter Andersen assumed this position in March 2001. Mr. Andersen has a master's degree in Health Education from the University of Virginia (1976) and a Master of Business Administration from Delaware State University (1989). He has been in the public health field for over 20 years. The first eleven were with the Delaware Division of Public Health in a variety of chronic disease program management positions. His eight previous years with the North Carolina state health agency have been in positions in health promotion and chronic disease prevention.

Women's Health Branch Head - Dr. Joe Holliday replaced Dr. Kevin Ryan as Women's Health Branch Head in February 2000. Dr. Holliday has over 30 years of public health leadership experience, including local health director positions in Virginia, South Carolina and North Carolina. Previous Division of Public Health duties included: program manager for the Comprehensive Breast and Cervical Cancer Control and Wise Woman Programs; and Chief of the Chronic Disease Prevention and Control Branch. He is a graduate of University of North Carolina at Chapel Hill, Vanderbilt School of Medicine, and the UNC School of Public Health (Department of Maternal and Child Health). He also completed a pediatric internship from Pittsburgh Children's Hospital and a preventive medicine residency from the School of Medicine, University of North Carolina.

/2012/ Dr. Holliday retired on July 1, 2011. Belinda Pettiford, the current Perinatal Health and Family Support Unit Supervisor in the Women's Health Branch, has been named interim branch head. Belinda has undergraduate degrees in psychology and community health education and earned her MPH in health policy and administration from the UNC School of Public Health in 1993. Prior to becoming the Unit Supervisor in 2000, Belinda served as the Program Manager of

the Healthy Start BabyLove Plus Program and as the Program Manager for the Minority Infant Mortality Reduction Program. //2012//

/2013/ Effective March 2012, Belinda Pettiford has been named the Head of the Women's Health Branch.

Medical Consultant for the Women's Health Branch - In October 2011, Dr. Isa Cheren was hired as the Medical Consultant for the Women's Health Branch. Dr. Cheren graduated from the Wake Forest University Bowman Gray School of Medicine in Winston Salem, North Carolina and completed her Family Practice Residency at the Maine Medical Center in Portland, Maine in 1991. Dr. Cheren also serves as a Public Health Physician with the Alamance County Health Department. In this capacity she provides services for women's health including maternity and family planning services. It is an asset for the Branch to have a practicing women's health physician providing medical consultation. //2013//

Children and Youth Branch Head - Carol Tant became Branch Head in February 2000. She has an undergraduate degree in psychology, and earned her MPH in health administration from the UNC School of Public Health in 1980. She worked in increasingly responsible positions in mental health, women's health, and children's health services. Carol's work experience in children's health for over 25 years has included positions in genetics, specialized services and preventive health at both the regional and state levels.

Nutrition Services Branch Head - Alice Lenihan earned a BS in food and nutrition from the College of St. Elizabeth (New Jersey, 1970), and a MPH in health administration from the UNC School of Public Health in 1983. After gaining local and regional experience in WIC programs, she was appointed state WIC Director in 1984. She continues to serve in that capacity as Nutrition Services Branch Head. In addition to the WIC program, she has oversight of the state's Child and Adult Care Feeding Program, Summer Food Service Program, and Nutrition Education and Training Program.

Immunization Branch Head - Beth Rowe-West assumed the position of Branch Head in December 1999 after serving in an acting capacity since October 1998. She earned her BS in Nursing from the University of North Carolina at Greensboro and has worked most of her career in public health, serving 11 years in a local health department prior to coming to the Immunization Branch as the Hepatitis B Coordinator in 1994.

Early Intervention Branch Head - Deborah Carroll assumed the position of Branch Head in March 2005. She received a BS in Speech Pathology from Appalachian State University, a MA in Speech Pathology-Audiology from UNC Greensboro and a PhD in Human Development and Family Studies from UNC Greensboro. She is licensed and board certified in Audiology. She worked from 1999 to 2003 in the EI Branch as Director of EI's Comprehensive System of Personnel Development. Most recently she was the Unit Manager of the Genetics and Newborn Screening Unit of the C&Y Branch of the WCHS.

Data Specialist/Needs Assessment Coordinator (State Systems Development Initiative Project Coordinator) - Sarah McCracken Cobb began working in this position on July 1, 2000. She completed her undergraduate degree in chemistry at the University of North Carolina at Chapel Hill in 1987 and earned an MPH from Boston University in 1989. After serving in the US Peace Corps, she has held assessment positions with the state health agency in HIV/AIDS, immunization, and maternal health programs.

Family Liaison Specialist - During FY04, the C&Y Branch filled the Family Liaison Specialist position by a family member of an adolescent with special needs, Marlyn Wells. She serves as staff to the Family Council, which works extensively with the staff of the C&Y Branch. She trains, assists and advises staff on the development and promotion of family related issues and activities such as family perspectives, family centered care, care coordination, transition planning, medical

home and educational/community resources. She also advises WCHS families on an as-needed basis on issues related to children with special needs.

/2012/ Ms. Wells resigned from the Family Liaison Specialist position effective June 30, 2011. The position has been posted. //2012//

/2013/ Effective May 2012, Suzanne Todd has been hired as the Family Liaison Specialist in the C&Y Branch. She had been working in an interim capacity in this role since August 2011. Her position includes staffing and managing the Branch-Family Partnership and the Help Line (1-800-737-3028) for families of CYSHCN. Her position also includes assuring that programs and services are family-driven by training, assisting and advising staff of the C&Y Branch on family related issues such as family perspectives, family centered care, care coordination, transition planning, medical home, and educational/community resources. She is the mother of a young adult child with special health care needs, and has been active as a volunteer and professionally as an advocate for persons with disabilities and their families for over 20 years. Her professional background has included working with the Family Support Network of Orange, Durham and Chatham Counties; the South Central NC Assistive Technology Resource Center; the Durham Developmental Evaluation Center; and the NC Family Health Resource Line. //2013//

Pediatric Medical Consultant for the C&Y Branch -- Dr. Gerri Mattson joined WCHS in this capacity in August 2005. She received her MD from the Medical College of Virginia in 1993, completed her internship and residency at Emory University in 1996, and received her MSPH from the School of Public Health at UNC in 2004. Her expertise is available to a wide range of public and private providers on best and promising practices in policy, program development, and evaluation related to child and adolescent health. She also works with staff members of other branches in WCHS as necessary. She has almost 18 years of experience in a variety of pediatric health care and public health settings.

E. State Agency Coordination

With creation of DHHS in October 1997, state-level public health, mental health, social services, Medicaid, child welfare, vocational rehabilitation, substance abuse, and child development programs are now administered from a single agency. The DHHS Secretary has weekly meetings of the directors of these programs. These serve as a forum for discussing common issues and for facilitating coordination of efforts. The DHHS Deputy Secretary for Health Services conducts regular meetings with the directors of the divisions and offices that he manages (Public Health; State Operated Healthcare Facilities; Office of Minority Health and Health Disparities; Division of Medical Assistance; Office of Rural Health and Community Care; Division of Health Services Regulation; and Mental Health, Developmental Disabilities, and Substance Abuse Prevention) Thus, intra-agency coordination is expected and facilitated at all levels of the organization. In addition, the Division is signatory to formal written agreements with several agencies, including:
-DHHS Division of Medical Assistance (DMA) for provision of Medicaid reimbursed services for the MCH population. The current agreement includes a wide array of services and defines joint responsibility for informing parents and providers of the availability of MCH and Medicaid services. This agreement is revised in its entirety every five years, with interim changes as needed.
-DPI (state education agency) for assuring the provision of multidisciplinary evaluation, special therapies, health and medical services, and service coordination. This agreement is updated every three years and meets the requirements of the Individuals with Disabilities Act (PL 102-119).
-DHHS Office of Research, Demonstrations and Rural Health Development (formerly Office of Rural Health and Resource Development). The state primary care agreement outlines the Division's relationships with community health centers and other primary care providers.
-DHHS Division of Vocational Rehabilitation Under this agreement, the Division assumes

responsibility for informing families of the availability of Supplemental Security Income (SSI), eligibility determination (when appropriate) and assurance that children remain under care.
-DHHS Division of Child Development (DCD) This agreement specifies collaboration in three areas: child care health and safety training calendar; a monthly family child care health bulletin; and support for the child care health specialist position that responds to health and safety issues through the 1-800-CHOOSE1 hotline. The hotline gives access to the resource center which provides training, technical assistance and information to child care health consultants, child care providers, and consumers. WCHS also is an active member of the Advisory Committee on Public Health Issues and Child Care.

The plan for coordination of the Title V program with the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and providers of services to identify pregnant women and infants who are eligible for Title XIX is described in Section A. Agency Capacity.

WCHS staff assure that information about health and social services is available to the target population by supporting the following toll-free information and referral hotlines:
-MCH Hotline - NC's Family Health Resource Line (1-800-FOR-BABY or 1-800-327-2229) has evolved from a prenatal care hotline to a multi-program resource. The hotline averages 3,500-4,000 calls a month and operates 24 hours a day, including holidays. In December 2009, the Family Health Resource Line became an automated system to triage calls and forward them to existing call centers based on the choices made by the caller. This change in service was prompted by a State budget crisis that required consolidation of existing hotline services. Calls relating to maternal and child health issues, family health, Health Check (Medicaid for Children) and NC Health Choice (North Carolina's Children's Health Insurance Program) are routed directly to the CARE-LINE, North Carolina Department of Health and Human Services' (NCDHHS) toll-free Information and Referral telephone service. Staff members provide information, advocacy and referrals for primary and preventive health services for children and youth and provides general perinatal information with special emphasis on reaching pre-conceptional and pregnant women.
-CARE-LINE (1-800-662-7030) provides general information about available social services.
-CSHCN Help Line (1-800-737-3028) provides information about genetic services and services for children with special health care needs.
-Family Support Network (1-800-TLC-0042) provides information about special health problems and the availability of services for children with special health care needs. (Meets Individuals with Disabilities Education Act [IDEA] requirements.)

DPH and WCHS staff work with DPI on a number of projects including a Centers for Disease Control and Prevention (CDC) funded grant to improve interagency coordination of health services offered by health and education agencies (CDC "infrastructure" grant), and nutrition programs. In addition, WCHS provides leadership, consultation and technical assistance to the state education agency and local school districts for:
-Development and maintenance of school-based and/or school-linked health centers,
-Expansion and enhancement of school nurse services,
-Nutrition and related training for food service workers, and
-Implementation of US Department of Agriculture (USDA)-funded summer food and nutrition programs.

Close working relationships are maintained with the UNC School of Public Health, particularly with its Department of Maternal and Child Health. Division staff members serve as adjunct faculty members and are frequent lecturers in the Department, in addition to serving on Departmental advisory committees. Faculty members are asked to participate in Division planning activities to provide review and critique from an academic and practice perspective.

Although local health departments operate as autonomous entities, the state health agency funds

a substantial amount of their services and the Division of Public Health works closely with them in all phases of program development, implementation and evaluation.

Strong relationships between state and local agencies are maintained by the continuous efforts of WCHS staff members to involve these agencies in the development, implementation and evaluation of WCHS initiatives. WCHS staff lead or participate in state-local collaborations that include, but are not limited to the following task force, on-going, or ad hoc working groups:
-Medicaid Outreach and Education
-Health Check Initiative
-Child Fatality Task Force
-Council on Developmental Disabilities
-IDEA Interagency Coordinating Council
-Smart Start Partnership for Children (Governor's early childhood initiative)
-Coalition for Healthy Youth
-Family Preservation/Family Support Initiative
-Healthy Child Care North Carolina
-Baby Love Program (enhanced services for pregnant women and infants)
-First Step Campaign (infant mortality reduction)
-Early Intervention Intra-agency Work Group
-WCHS/Medicaid Intra-agency Work Group

Adding to the success of these efforts is the strong involvement and participation of professional agencies in Division activities. The Division works closely with the medical societies (pediatric, obstetric/gynecologic, and family practice). The Division also maintains close working relationships with other advocacy and non-profit agencies that include the NC Partnership for Children, Prevent Child Abuse NC, and the NC March of Dimes.

The CCNC program is building community health networks organized and operated by community physicians, hospitals, health departments, and departments of social services. By establishing regional networks, the program is establishing the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients. The program office is based in Raleigh at the North Carolina Office of Rural Health and Community Care. The program office is sponsored by the Office of the Secretary, the Division of Medical Assistance, and the North Carolina Foundation for Advanced Health Programs, Inc. Additional grant funding has been obtained for start-up and for pilot demonstrations from Kate B. Reynolds Health Care Trust, the Commonwealth Fund, and the Center for Healthcare Strategies. The North Carolina Foundation for Advanced Health Programs, Inc. is a private non-profit organization that also serves to provide staffing and grant funding opportunities.

In 2002, the NC DPH and the North Carolina Association of Local Health Directors undertook an initiative to develop a mandatory, standards-based system for accrediting local public health departments throughout the state. Since 2002, the North Carolina Institute for Public Health (NCIPH) has provided Accreditation staff support.

The focus of North Carolina's Local Health Department Accreditation (NCLHDA) is on the capacity of the local health department to perform at a prescribed, basic level of quality the three core functions of assessment, assurance, and policy development and the ten essential services as detailed in the National Public Health Performance Standards Program. The program focuses on a set of minimal standards that must be provided to ensure the protection of the health of the public, but does not limit the services or activities an agency may provide to address specific local needs. NCLHDA does not create a wholly new accountability system; rather it links basic standards to current state statutes and administrative code, and the many DPH and NC Division of Environmental Health (DEH) contractual and program monitoring requirements that are already in place.

The program comprises three functional components:
-An agency self assessment, which includes 41 benchmarks and 148 activities
-A three day site visit by a multidisciplinary team of peer volunteers, and
-Determination of accreditation status by the North Carolina Local Health Department Accreditation Board.

The program process is adjudicated by an independent entity, the North Carolina Local Health Department Accreditation Board. Its members are appointed by North Carolina's Department of Health and Human Services Secretary. The Accreditation Administrator within the NCIPH serves by legislative mandate.

Accreditation is achieved by appropriately meeting a set of capacity-based Benchmarks as evidenced by documented completion of prescribed Activities. Benchmarks may be met by either direct provision or assurance (through contracts, memoranda of understanding, or other arrangements with community providers) of required services and activities. While the Benchmarks being applied are similar to the Operational Definition of a Functional Local Public Health Agency by the National Association of County and City Health Officials (2004) and drawn from work done in other states, the Activities are specific to practices in North Carolina local public health agencies.

As of July 2009, 50 local health departments had been accredited. Due to budget cuts in FY10, the accreditation program was suspended for the FY10 period.

/2012/As of July 2011, 56 local health departments have been accredited.

Due to budget cuts, on July 1, 2011, the CARE-LINE was shut down. The NC Family Health Resource Line still exists as an automated system to triage calls and forward them to existing call centers based on the choices made by the caller. Instead of being directed to the CARE-LINE, an additional option was created asking callers to call their local health department for information about items not already covered by other options that go to call centers (e.g., Health Check, Health Choice, CSHCN, and substance abuse). //2012//

/2013/ Since 1998, NC has been implementing an enhanced medical home model of care in its Medicaid program called Community Care of North Carolina (CCNC). Beyond linking individuals with a provider as a medical home, it incorporates a heavy emphasis on care coordination, disease and care management, and quality improvement. Evaluations of the program suggest it has resulted in both improved care and cost savings. The C&Y Branch partners with the networks to assure children's preventive, specialty and care management services are provided as needed.

The program has built-in data monitoring and reporting to facilitate continuous quality improvement on a physician, network, and program-wide basis. Many of the C&Y Branch programs, especially for CSHCN, are jointly planned and implemented with the CCNC networks and support services through a medical home model for continuity and coordination. About a third of the health departments are now providing primary care. Others provide well child clinics and preventive services through a network of specially trained and certified RNs.

C&Y Branch staff members interface in a wide variety of ways with all other child and family service providers including public and private entities. This is accomplished through ongoing and regular meetings both individually and through committees with key partners to identify and address potential barriers and opportunities affecting both services and capacity. The majority of partnerships for planning, information gathering, and evaluating/monitoring services are obtained through widespread participation by C&Y Branch staff in committees, task forces, councils, commissions, workshops and conferences. Branch staff members represent a broad range of disciplines including

clinical specialists, consultants, managers, and administrators. Each staff member is responsible for establishing a network of public and private partnerships to assure ongoing collaboration, information exchange and coordinated planning, implementation and monitoring. Unit managers assure that this representation encompasses every possible child/family health system that influences healthy development and family/child interactions.

DMA plays an important role in policy development for services that are reimbursed by Medicaid. Issues that require negotiation are addressed through a monthly "Issues Meeting" that involves Division Directors and appropriate Branch Heads in DPH and DMA. The C&Y Branch is constantly in touch with the DMA because many of the services for children and families are directly affected by Medicaid policies. The C&Y Branch Pediatric Medical Consultant attends and is actively involved in the Physician's Advisory Group (PAG) that reviews and approves health, mental health, and social policies for women and children.

The Commission on CSHCN was established by the NC General Assembly during the 1998 Special Session as part of the act establishing the children's health insurance program. Members were appointed by the Governor and have met bi-monthly since December 1998. The Commission has ten members recommended by their respective professional associations and representing the following areas of expertise: psychiatric, psychology, pediatrics, children's hospital representative, public health director, special educator, dental and two parents of children with special health care needs. The Commission monitors and evaluates availability and provision of services to children with special health care needs in NC. As appropriate, the Commission makes recommendations to the Governor, the legislature, state agencies, or others regarding needed changes or proposed policy revisions. Over time the Commission has created two working groups, the Oral Health Workgroup with ten members and the Behavioral Health Workgroup with eight members. The C&Y Branch provides staffing support for all three groups. Meetings have been well attended and productive.

The NC Institute of Medicine (NCIOM) has conducted a series of Task Forces during the past five years involving subject experts and providers in developing recommendations for legislative and agency action. These include Early Childhood Behavioral Health, Substance Abuse, Transition of Adolescents with Developmental Disabilities, Adolescent Health, Prevention, Access to Care and Dental Care, and Implementation and Support of Evidence Based Programs in Communities. The working groups for each Task Force come together annually to measure progress and update priorities. The WCHS is very fortunate to have this mechanism for obtaining and providing information with persons most involved in these major service areas. Task Force meetings are open to everyone and, therefore, include family members of children with special needs.

The NCIOM facilitated the Adolescent Health Task Force in order to heighten awareness among policymakers, practitioners, the media and the general public about the issues and conditions facing adolescents in NC and the various opportunities to provide support for this population. The Adolescent Health Task Force was a joint effort of the North Carolina Metamorphosis Project (NCMP); the University of North Carolina at Chapel Hill (UNC-CH) School of Medicine and Gillings School of Global Public Health; the North Carolina Multisite Adolescent Research Consortium and Coalition for Health (NC MARCH); the NCIOM; Action for Children North Carolina; and DPH. The Task Force members heard presentations from state and national experts on health and safety issues facing adolescents and young adults in NC and evidence-based and promising practices and interventions to improve the health of young people between ages 10 and 20. The Task Force members, including legislators, state and local agency officials, educators, primary care providers and other health care professionals, consumers, and other interested people, dedicated approximately one day a month for over a year to develop a total of 32

recommendations to improve adolescent health in NC. The Task Force issued multiple recommendations for improving adolescent health. No funding was made available to implement those recommendations. The C&Y Branch is trying to fill an Adolescent Health position to begin creating an Adolescent Health Center for the state which would include CSHCN.

An important partnership that promotes the health and wellness of people with disabilities is with the North Carolina Office on Disability and Health (NCODH). This is a grant funded program supported by the CDC that focuses on health promotion, access to care, and emergency preparedness for people with disabilities. This office includes a director, supported with Maternal and Child Health Bureau funds, and two Regional Disability and Health Specialists, funded through the CDC grant. The Director provides oversight and direction and is responsible for assuring that initiatives are integrated within the state infrastructure. The Regional Disability and Health Specialists work with local public health initiatives and agencies to improve health promotion, access to care, and emergency preparedness efforts for people with disabilities. The focus is on improvement of policies and systems interactions that address persons with disabilities. The program interacts with a wide range of other state and local systems of care to assure that they consider and include persons with disabilities in their planning and service interventions.

Linkages with DPI are primarily through School Health, Nutrition, EI, ODH, Child and Family Teams, Immunization and Healthy Schools Initiatives. The C&Y Branch subcontracts for about 18% of the school nurse positions located in health departments, schools or hospitals, but is responsible for planning, training and consulting with all 1,223 school nurses. The State School Nurse position is located in the C&Y Branch and works directly with DPI and the Lead Education Agencies to coordinate and lead school nursing services across the state. The Healthy Schools Initiative CDC grant in NC focuses on improving and linking the DPH and DPI infrastructures. The C&Y Branch directly funds 35 school health centers (a portion of their total operating costs) and coordinates with the remaining 28 centers. Center management requires a coordinated effort with DPI, the communities and the Branch to assure appropriate services are available to the school aged children impacted. Among many other duties, the school nurses provide care and case management for children with chronic health problems and monitor security and safe administration of medications. About one in every eight children attending school in NC has a chronic health condition. During SY11, the most common chronic health conditions of K-12 public school students in NC included 101,599 cases of asthma; 63,689 children with ADD/ADHD; 24,806 with severe allergies, and 4,854 with diabetes. School nurses work with their local School Health Advisory Councils (SHAC) to develop and implement local programs designed to prevent illness, manage disabilities and promote health.

Other strong linkages are in place with the DCD, Division of Mental Health, Developmental Disabilities, and Substance Abuse (DMH/DD/SAS), DSS, Office of Rural Health, and the Department of Juvenile Justice and Delinquency Prevention. Some examples of partnerships with these agencies are listed below.

Early childhood services are coordinated under the umbrella of the Governor's Office, the Early Childhood Advisory Council, and the Early Challenge grant. The State ECCS grant project provided NC with a neutral platform to plan, develop, and ultimately implement collaborations and partnerships to support families and communities in their development of children who are healthy and ready to learn at school entry. This included identifying and linking with individuals and groups with expertise in system-building and relevant content expertise including access to health insurance and medical homes, mental health and social-emotional development, early care and education, parent education and family support. The ECCS grant project outlined a proposed organizational structure for an Early Childhood Advisory Council that included representation from all subcomponents of the early childhood system, a shared staffing structure that would involve staff from all key

early childhood agencies and a funding partnership to support ongoing activities of the Council. The Governor developed North Carolina's Early Childhood Advisory Council to be comprehensive in nature and designed to address the whole early childhood system rather than a subcomponent of the system. The decision to take a comprehensive approach means that North Carolina's Early Childhood Advisory Council will provide an opportunity to build on the comprehensive system building approach that has guided the ECCS grant project in NC.

The NC Pediatric Society is very strong. They have used Commonwealth Fund support to implement the "Assuring Better Child Health and Development (ABCD)" model to promote best practices among all primary care physicians serving children in the state including: use of valid developmental screening tools; effective communication of results; and appropriate referral and follow-up to ensure the family receives needed care. Designed to support the social and emotional development of young children birth to three years old, ABCD is an intervention in primary care settings, with the goal that all children receive appropriate developmental screenings and referrals in the context of the medical home. While pediatricians championed this practice in private practices, Title V staff utilized the same model to improve care in the health department setting. During the past five years the C&Y Branch has worked closely with the Pediatric Society in linking children in foster care with medical homes, implementation and strengthening of medical homes for all children, and a recent Children's Health Insurance Program Reauthorization Act (CHIPRA) grant to use the kindergarten health assessment information to expand enrollment in Medicaid (Health Check) and the CHIPRA (Health Choice) programs in NC.

Title V staff have partnered with the Office of Rural Health, DMH/DD/SAS and private practitioners to implement a model of care that adds a mental health provider to the CCNC physician network in order to assist pediatricians and other primary care providers that serve uninsured children and/or children on Medicaid in the use of appropriate behavioral health screening tools and to promote appropriate referral of children who show signs of problems to a well-trained mental health provider who has demonstrated positive outcomes. The C&Y Branch recently hired a behavioral health specialist, a psychologist, to work half-time on school issues and half-time on early childhood issues. Another position is currently being reclassified to expand the C&Y Branch's behavioral health capacity because of the increasing demand for these services. These positions will consult with home visitors, early childhood care and education providers, health departments, CCNC practices, school nurses, school health centers, teachers, Triple P providers and others as appropriate.

Insurance for children in NC is addressed through a variety of groups. The C&Y Branch has lead responsibility for managing services for CYSHCN and outreach for all children to increase enrollment in the NC Health Choice Program for Children, the CHIPRA Program. In developing and implementing services for this program, the DPH works closely with: the DMA, lead for the NC Health Choice Program for Children; Hewlett Packard, the claims processing contractor; NCPS; Value Options, utilization review agency for behavioral health services; Branch/Family Partnership; and the statewide Coalition for Advancement of Health Insurance in NC that focuses on effective outreach strategies. Priorities are jointly set and reviewed within these organizations on a regular basis.

Child Care Health Services are addressed through a combined effort of the DPH, the Division of Child Development (DCD), NC Partnership for Children, Smart Start local agencies, Head Start and UNC-CH. For the past several years these agencies have focused on institutionalization of a training curriculum for health professionals preparing to work as child care health consultants. A pooling of funds from DPH, DCD, and local Smart Start agencies provided a foundation for success in this effort to make child care health consultants available in the majority of communities. Using the Blueprint for Action, DPH, in conjunction with key partners, fosters higher immunization rates, improved

access to medical homes, more inclusive child care environments, better nutrition, earlier identification and referral of children at risk, better worker health, and stronger health and safety policies at the state and community levels. The primary role of the local child care health consultants is to improve the health and safety of children in out-of-home-child care. They provide consultation and training for child care providers, parents and children. The local, regional and state consultants focus on activities that will decrease the mortality and morbidity of children in out-of-home child care by encouraging and supporting DCD licensing regulations as well as the national health and safety standards.//2013//

F. Health Systems Capacity Indicators

Data are available for all of the Health System Capacity Indicators (HSCIs) through a variety of sources, but primarily through the State Center for Health Statistics (SCHS) from birth files, hospital discharge records, Medicaid records, linked/matched datasets, and various surveillance systems.

After years of complex system development, in August 2010, the North Carolina's Vital Records office launched the web-based "Vital Records Automation System" (VRAS) in delivery hospitals across the state. VRAS was designed to improve the timeliness of birth registration and Vital Statistics data dissemination as well as to implement the 2003 U.S. certificate standards. The new web-based birth registration system was rolled out hospital by hospital and by the end of 2010, all hospitals in the state were transmitting birth data to the state Vital Records office through the new registration system. As a result of this staggered implementation, North Carolina birth data were collected under both the 1989 and the 2003 birth certificate standards in 2010. Therefore, the SCHS was unable to publish any data from the new or modified fields for 2010 births. Fields that were not comparable across the two certificate revisions, such as maternal smoking, prenatal care and congenital anomalies were left blank in the 2010 birth file and were not reported in the 2010 Vital Statistics reports. Beginning in 2011, birth data were collected solely under the revised U.S. Standard Certificate, therefore, 2011 will represent the first full year of revised birth certificate data that the SCHS will publish. Researchers and other data users of North Carolina birth data will need to be careful not to compare trends in certain key public health indicators, such as prenatal care, race, smoking, and maternal education levels across the two revisions.

Because of this implementation, data for CY10 are not available for the following HSCIs:
4. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are great than or equal to 80 percent on the Kotelchuck Index;
5C. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester; and
5D. Percent of pregnant women with adequate prenatal care.

In preparing the state's response to HSCI #9(A) of the MCH Title V Block Grant application, the WCHS consulted with the SCHS to answer the data capacity questions. Overall, North Carolina is able to score itself very high for this measure. North Carolina has a long history of linking birth records and infant death certificates, Medicaid eligibility or paid claim files, and WIC eligibility files. There has not been a data linkage between birth certificates and newborn screening files, but with the recent implementation of the new electronic birth registration system in 2011 which utilizes the 2003 standard birth certificate, matched data files of birth certificates and newborn screening records should be available no later than 2012.The SSDI Project Coordinator will work with staff members of SCHS on this matching project. Data resulting from the match will be placed on the SCHS web site.

For the remainder of the HSCIs, trend data show that they remained fairly constant over the past five to ten years.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Data collection and analysis for the majority of the National and State Performance measures are done collaboratively by staff within the WCHS and the State Center for Health Statistics. Specific information regarding most of these measures, including data sources and trends, can be found in the narrative portions for each measure and the detail sheet. Data from the 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN) were pre-populated into the respective National Performance Measures. Due to changes in the survey questionnaire (substantial additions to questions, wording changes, ordering and placement of questions, and skip pattern changes), only data for National Performance Measures #2 (families are partners in decision making and satisfied with services that they receive) and #4 (adequate health insurance) are comparable to the outcomes found in the 2001 NS-CSHCN.

/2012/ In 2010, the Health Information System was rolled out to local health departments, replacing the Health Services Information System. Statewide data from the new system are being placed in the Client Services Data Warehouse, but at this time the warehouse does not have all the service data needed for some of the MCH Block Grant indicators and forms. These forms will be updated with current information as the data become available, but for the application, some indicators are populated with data from previous years. //2012//

/2013/North Carolina adopted the 2003 revision of the U.S. Standard Certificate of Live Birth beginning in August 2010. Birth data was collected according to the 1989 U.S. standards from January through July of 2010. Data items related to educational attainment, prenatal care initiation, and tobacco use were collected differently on the 1989 and 2003 revised certificates and are not comparable. As a result, some 2010 performance measures and indicators are not available.//2013//

B. State Priorities

The WCHS conceives of priority-setting as a continuous process, in which useful data, both quantitative and qualitative, relevant to the broad mission of the section are continuously being gathered and analyzed with an eye to adjusting the priorities and the activities of the section as appropriate. In addition to these day-to-day "micro" analyses of relevant inputs, the section utilizes formal needs assessment processes, such as the five year MCH Block Grant (MCHBG) needs assessment process, to review and titrate section priorities and activities. In order to give a background context for the section's activities with respect to priority-setting in association with the MCHBG needs assessment process, some information about antecedent section priority-setting activities is provided.

During FY03, the SMT defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. These indicators are the following:

1. Reduce infant mortality
2. Improve the health of women of childbearing age
3. Prevent child deaths
4. Eliminate vaccine-preventable diseases
5. Increase access to care for women, children, and families
6. Increase the number of newborns screened for genetic and hearing disorders and prevent birth defects
7. Improve the health of children with special needs
8. Improve healthy behaviors in women and children and among families

9. Promote healthy schools and students who are ready to learn
10. Provide timely and comprehensive early intervention services for children with special developmental needs and their families.

The purpose of defining the set of indicators was to be able to help the WCHS better define its mission and promote a common vision among staff. In addition, as these indicators are shared with stakeholders and policymakers, they provide information about how the work of the WCHS contributes to the welfare of the state. The process of defining the indicators also helped the SMT gain clarity about where evidence-based interventions exist and identify areas offering opportunities for improvement. Also, the choice of indicators helps Section staff understand core job responsibilities and evaluate performance as the indicators can be used in individual work plans. Another important outcome of the selection of indicators is that they allow for a more data-driven environment throughout the WCHS.

During the 2010 MCH needs assessment process, SMT members found that the broad priority areas previously identified provided an excellent template for describing to federal, state and local stakeholders the charges given in North Carolina to the WCHS. While other states may use the needs assessment process to identify more narrow or more specific priorities, such as "improve school nurse to student ratio in public schools," or "increase the number of disorders screened by the newborn metabolic screening program," our approach, in which we aim to identify the full range of activities we are charged to support, seems to work well for us.

Because we are using such broad, inclusive categories, it has seemed reasonable to leave them unchanged--we feel no needs assessment process would ever lead us to conclude, for example, that "reducing infant mortality" or "improving the health of children with special needs" would not be a priority area for us. What the needs assessment has done, of course, is to provide us with a wide range of data that are allowing us to refine our strategies for reducing infant mortality, improving the health of children with special needs, and all of the other priority areas we have identified.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	220	257	219	231	220
Denominator	220	257	219	231	220
Data Source		NC State Laboratory of Public Health	NC State Laboratory of Public Health	NC State Laboratory of Public Health	NC State Laboratory of Public Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY10 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, Biotinidase Deficiency, Short Chain AcylCo-A Dehydrogenase (SCAD), GA-I, VLCAD, IVA, MSUD, IBDD, TFPD, and HPA.

Notes - 2010
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY09 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, Biotinidase Deficiency, Short Chain AcylCo-A Dehydrogenase (SCAD), GA-I, VLCAD, IVA, MSUD, IBDD, TFPD, and HPA.

Notes - 2009
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY08 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, Biotinidase Deficiency, Short Chain AcylCo-A Dehydrogenase (SCAD), GA-I, VLCAD, IVA, MSUD, IBDD, TFPD, and HPA.

a. Last Year's Accomplishments
Key branch staff participated in the January meeting of the NC Newborn Screening Advisory Committee (NSAC). At the meeting the NSAC reviewed and discussed implementing revisions to the State Laboratory of Public Health's (SLPH) unsatisfactory specimen policy revisions and voted to add Severe Combined Immunodeficiency Syndrome (SCID) to the screening panel in NC

The Newborn Screening (NBS) Follow Up Coordinator continued to track and report newborn screens with abnormal results to the physician of record, make and monitor follow-up testing recommendations, and document final outcomes including treatment and subspecialist involvement for those confirmed to have a condition. The Coordinator continued to partner with NC's accredited and affiliated cystic fibrosis (CF) centers, and also one in Virginia, to assist with timely sweat chloride testing to definitively diagnose CF, to offer genetic counseling for carriers as well as affected newborns, and to facilitate timely management of newborns identified with CF. She continued to work closely with the pulmonologists at the state CF centers and the State Lab to make modifications to the NBS screening protocol for CF based on over two years of experience with CF screening and sweat chloride testing results. She worked closely with the endocrinologists and geneticists at the major medical centers and the SLPH to document short-term follow-up for congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia, and biotinidase deficiency. She provided technical assistance (TA) to local health department (LHD) staff about individual NBS results and information for clients.

Regional genetic counselors provided counseling services to families for newborns affected with

CF, newborns that are CF carriers, and to newborns with other NBS identified conditions.

Immunologists at the University of North Carolina at Chapel Hill (UNC) continued to provide follow up to the patients identified by the tandem mass spectometry (MS/MS) screening. UNC completed the first phase of an MS/MS project involving Michigan (Dr. Beth Tarini) and NC (Dr. Dianne Frazier) to design and implement a survey to see how follow-up is done for positive MS/MS newborn screening results throughout the US. This work was presented at the 2011 Society of Inherited Disorders of Metabolism.

The SLPH made changes in workflow including lab-wide centralized data entry, utilization of electronic data feed from WCS Web, and centralized specimen accessing in anticipation of moving to a new facility. A Clinical Laboratory Improvement Amendments (CLIA) inspection was held April 12-15, 2011 of the SLPH. The SLPH began the process of revising the newborn screening fee charge policy and continued to make improvements to enhance the functioning of the Starlims web application for newborn screening reporting. The process for updating procedure manuals began to reflect the transition to the new Laboratory Information Management System. The SLPH introduced a new unsatisfactory specimen policy on 5/2/11 in an effort to reduce the number of unsatisfactory NBS specimens. The NBS SLPH manager attended the severe combined immunodeficiency syndrome (SCID) meeting in October. The SLPH completed an update of the online Newborn Screening Training program to offer health care providers training opportunity for form completion and specimen collection. The SLPH staff also conducted several in-service trainings for Forsyth Medical Center and Wake Medical Center and participated in a Hearing Link meeting at Duke Hospital to discuss the implementation of remote data entry from Duke.

A Social Security Administration site visit occurred in March to investigate the usage and collection of mother's social security number in NC.

The newborn screening lab manager and WCSWeb EHDI data manager participated in the CDC RUSH grant application, site visit, meetings and data extractions related to sickle cell screening and follow up.

Two key SLPH staff members that support the NBS program left their positions. The Hemoglobinopathies/CF supervisor resigned from her position in April 2010 and the clerical supervisor retired in April 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Initial newborn screening test performed on all blood spot samples received.			X	
2. Follow-up of borderline results with a letter to physician.			X	
3. Follow-up of abnormal results with a phone call to physician.			X	
4. Testing of repeat blood spots received following a borderline or abnormal screen.			X	
5. Continued interaction of state lab and medical center staff as relates to questionable results.				X
6. Contracts providing statewide coverage for consultation related to metabolic conditions.				X
7. Work towards development of data linkage of birth certificates and newborn screening records.				X
8. Assure special formula for individuals with certain metabolic disorders through Nutrition Services, Medicaid, Health Choice, or		X		

other payors.				
9. Monitoring of phenylalanine, tyrosine, and phe/tyr ratios in blood spots received from individuals with Phenylketonuria in routine medical management.			X	
10. Newborn screening advisory committee quarterly meetings.				X

b. Current Activities
In the December 2011 NSAC meeting, the numbers of cases and follow-up process for several conditions identified through NBS in 2010 were discussed. There was also a vote to change the follow-up procedure for the D1270N CF mutation.

The SLPH, Duke University, and Advanced Liquid-Logic are developing methodologies for screening of Lysosomal Storage disorders. The SLPH provided in-service training at Halifax Regional Hospital and presented the NBS Update Web Conference to health care providers in October 2011. Several policies and procedures related to infant death, NBS device management, record keeping, and validation of the filter paper are being updated by the lab.

The SLPH has resumed mailing monthly Sickle Cell reports to counties and programs and updated its web information. The new hemoglobinopathies supervisor started work in February 2012.

The MS/MS follow-up team at UNC provides statewide consultation and is trying to establish a secure source of medical foods (including metabolic formula) for people diagnosed with an inborn error of metabolism. This team contributes screening data to the Region 4 Collaborative, uses statistical analyses to modify cut-offs for out-of-range samples (the cutoff of C16 was changed), and works with the SLPH to improve timely and informative web-based reporting of results. Michigan and North Carolina continue work on the project to compare physician and consumer experience with receiving positive MS/MS NBS results.

c. Plan for the Coming Year
The NBS Laboratory is scheduled to move in September 2012. The SLPH staff will work with the administration staff to plan the move. To further increase laboratory efficiency through automation, an upgrade in laboratory instrumentation is planned in 2012. In the Hemoglobinopathies laboratory, three high-performance liquid chromatography (HPLC) systems will replace the manually intensive Isoelectric Focusing systems (IEF) as the initial screening test. IEF will be the second tier testing. An automated system will replace the continuous flow technology for galactosemia and biotinidase deficiency testing. Similarly, upgrades in newer technology for MS-MS and for T4/TSH, CAH, and IRT testing will also be implemented in 2012. All of these upgrades will improve the sensitivity of the testing, increase the efficiency and effectiveness of the workflow, decrease the turnaround time and ultimately provide more timely and accurate results. The implementation of Tyrosinemia I screening is planned after the move.

The NSAC recommended adding SCID, a primary immunodeficiency disease, to the panel at its meeting in January 2011. When funding for screening for this new disease and follow up is approved by the NC General Assembly in the future, it is likely that a high throughput, DNA-based test that measures T cell Receptor Excision Circles (TRECs) will be employed.

The NBS Follow Up Coordinator will continue to track and report newborn screens with abnormal results, offer/monitor follow-up testing recommendations, document final outcomes, provide TA to LHDs, and private providers about individual NBS results and provide information for patients and their families. The NBS Follow-Up Coordinator, public health educator (vacant), and pediatric medical consultant (PMC) in the Branch will work with the immunologists at Duke and UNC to develop a follow-up protocol and educational materials for the addition of SCID to the newborn screening panel. They will also work with the SLPH and cardiologists at Duke to determine the SLPH and Branch staff roles in the event that critical congenital heart disease screening is

implemented at birthing hospitals across the state.

The Branch pediatric medical consultant will continue to do outreach to health care providers about the resources and support for short term follow-up of patients identified through the NBS program.

The SLPH is working to establish Memoranda of Understanding (MOU) for NBS testing with other public health laboratories.

The NBS lab will be a training site for biomedical/medical genetics fellows from the UNC Medical Genetics Program to start in July 2012.

Efforts toward data linkage of birth certificates to NBS records/results will continue.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**122302**					
Reporting Year:	**2010**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	121081	99.0	91	8	8	100.0
Congenital Hypothyroidism (Classical)	121081	99.0	170	56	56	100.0
Galactosemia (Classical)	121081	99.0	14	11	11	100.0
Sickle Cell Disease	121081	99.0	115	115	115	100.0
Biotinidase Deficiency	121081	99.0	3	2	2	100.0
Maple Syrup Urine Disease	121081	99.0	5	1	1	100.0
Other	121081	99.0	89	4	4	100.0
Propionic Acidemia (PPA)	121081	99.0	1	1	1	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	121081	99.0	3	3	3	100.0
Isovaleric Acidemia	121081	99.0	72	0	0	
3-	121081	99.0	43	4	4	100.0

Methylcrotonyl-CoA Carboxylase Deficiency						
Methylmalonic acidemia (Cbl A,B)	121081	99.0	129	1	1	100.0
Trifunctional Protein Deficiency	121081	99.0	3	0	0	
Glutaric Acidemia Type I	121081	99.0	15	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	121081	99.0	60	4	4	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	121081	99.0	26	5	5	100.0
Mat 3 - MCC	121081		0	4	4	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75	75	75	75	75
Annual Indicator	58.3	58.3	58.3	58.3	74.6
Numerator					
Denominator					
Data Source		2005-06 CSHCN SLAITS Survey.	2005-06 CSHCN SLAITS Survey.	2005-06 CSHCN SLAITS Survey.	2009-10 CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	75	75	75	75

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure.

a. Last Year's Accomplishments
Major program areas of continuing focus included Branch/family interaction and advisory group/committee participation; Triple P; Innovative Approaches (IA); Newborn hearing and metabolic screening; late onset hearing loss; genetic services; CC4C care management/medical homes; EI; SSI follow-up; evidence-based parenting programs; Bright Futures as a standard of care guide for child health services; dental health; Commission for CSHCN; families active involvement in community planning; and work with Latino and other minority CSHCN.

The four pilot IA projects expanded the inclusion of parents of CSHCN in identifying systems improvements, seeking the input of parents through multiple focus groups and parent concern report surveys. The information gained from these activities creates the opportunity for a better system of care for CSHCN. In Buncombe County, to help sustain parent involvement in decision-making at all levels of their children's care, the formation of the Parent Alliance Group and the Pediatric Practice Collaborative were major achievements to ensure the continuation of their work. Truly feeling integrated with the community planning process remained a challenge for the families in the IA counties. Staff will continue to work with families to document lessons learned and ideas for an easier replication process across the state.

Since travel was frozen and staff members were unable to access training, the Branch management designed a series of web based training for staff and families of CSHCN to focus on the categories of early and adolescent brain development and toxic stress; systems of care for CSHCN; and trauma focused behavioral health issues. Expert speakers presented not only to C&Y Branch staff, but also included LHD nurses and social workers, DSS workers, Smart Start agency staff, child care staff, mental health, family members and others. Each presentation session lasted several hours followed by team discussions of how the information impacted current work strategies and how services could be improved for CSHCN and the NCODH.

Although the family liaison specialist (FLS) position was vacated and the family resource line staff was lost to DMA, a temporary person with resource line experience was hired half-time to maintain the most important parts of both positions. Several meetings with the steering committee of the former Family Council were held to hear ideas for improvements in Branch/family interactions and decision making structures. Participation was opened to all families of CSHCN. The decision was made to outline all of the areas of service provision and ask family members to indicate their level of interest for participation and sign an agreement to work with staff in those areas. Funds for family involvement were increased by $30,000. Each of

the four units in the Branch currently have $8000 of dedicated funds to pay families for participating in program activities including program meetings, trainings, advisory committees, material development, evaluations, co presentations, etc. Remaining funds are used to support meetings of the newly formed Branch-Family Partnership (BFP) and available to the Branch Head to support family involvement. Families are now dealing directly with staff and forming stronger relationships rather than working through the FLS position.

Service improvements for CSHCN in the school health centers and in schools with school nursing interventions were an area of interest during the year. A case management system for school health, tested and researched by East Carolina University, was offered to school nurses statewide, and statewide implementation was initiated. Meetings were held with parents, school health staff and medical staff to begin discussions on supporting a continuum of services between the medical provider and school nursing personnel.

The strong linkage with CCNC, with its related training, education, care management both for birth to five and school age children, and joint planning, strengthens the medical home model and provides for a stronger continuum of services for CSHCN and their families.

Although there are a few genetic counselor vacancies, satellite clinics are being covered by remaining staff to assure access for families.

Families affected by CSHCN Title V services periodically receive satisfaction surveys, no less than annually. Periodic family focus groups are also implemented to obtain current feedback from families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. With the support of the Family Liaison Specialist, involvement of families of CYSHCN in the Branch/Family Partnership and on program, planning and evaluation committees of WCHS and systems of care partners.				X
2. Toll-free Help Line continues to provide information and support for families of CYSHCN.		X		
3. Parent members continue to work with the NC Commission on Children with Special Health Care Needs, the UNC MCH Leadership Training Program, newborn hearing and metabolic programs, and receive standing invitations to Branch meetings.				X
4. At least two representatives from the Branch/Family Partnership attend AMCHP conferences.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A year long planning process with families has informed Branch/family interactions through the use of surveys, in-depth discussions and a day-long meeting to determine optimum representation on councils/boards/planning groups and to contribute in co-trainings, community outreach, and decision-making activities. A day was set aside to build relationships and link families' foci of interest with appropriate staff. Access to families has been restructured in the Branch and positive relationships among staff and families have increased dramatically.

A Summit on Cultural & Linguistically Appropriate Services (CLAS) was held in March with speakers from migrant health, LHD, and Latino autism outreach projects focusing on partnering with families and expanding linkages.

The temporary half-time staff member who was providing coverage for both the FLS and the CSHCN Help Line vacancies while trying to unfreeze the positions was hired full-time in June.

Families working with the EHDI program developed posters and facilitated CARE workshops and HITCH UP family support sessions. A second family liaison position was filled in October.

Parents participate in training school nurses regionally by presenting at orientation and practice update sessions to provide a family perspective on school nursing practice. Out of these sessions come suggestions for program improvement and problem-solving and a renewed sense of partnership between school nurses and parents.

c. Plan for the Coming Year

The new staff member filling the FLS/CSHCN Help Line position will be trained, oriented and begin joint planning with families. An individual will be identified and cross trained to provide backup coverage.

Family partners will continue to participate on ongoing committees such as EHDI, NBS, IA, NCODH, School Health Care Management Advisory Committees, and the Commission for CYSHCN including the Behavioral Health and Oral Health work groups. The Branch provides financial support through stipends, travel and subsistence reimbursement. Recommendations to the Branch, DPH, and DHHS leadership related to services for CYSHCN are actively sought from family partners.

The family liaison for the EHDI Program will continue to provide training, education and support for families. A resource directory of Spanish-speaking families willing to provide peer support to other families whose children have hearing loss is planned for next year. It will be shared with appropriate Spanish-speaking families statewide.

Both staff and families will jointly attend local interagency coordinating council (LICC) monthly meetings, teleaudiology testing, Partnering for Progress National EDHI Meeting, the Investing in Family Support conference, and the Early Intervention Hearing Loss & Cochlear Implant Symposium.

The Branch will continue to coordinate regular focus groups and strategic planning sessions with families of CSHCN to improve relationships and to ensure that effective family-centered care principles are included in Branch presentations such as in the regional child health consultant trainings .

The Branch/family partners are jointly investigating optimum use of social networking. A pilot "regional" parent meeting will be held in the Western part of the State to test feasibility of outreaching to families through this model.

Continued support for training staff and local providers by Family United trainers will be provided, and Triple P will be implemented for effective partnering.

Lessons learned from the Innovative Approaches' counties on effective integration of parents into all aspects of CYSHCN systems planning at the local level will be utilized in the new counties to be funded. Existing sites will provide a written outline of suggestions and barriers encountered at the State and local levels in work and effective partnership among children, families and providers.

The Branch will develop a series of webinars for training that will be accessible to the family partners in clinical topic areas, orientation to the Branch, training for committee participation and co presentations.

Families will be directly involved in the planning and roll out of Triple P in the 7 to 10 counties implementing the program this fiscal year.

The Branch will also "pilot" regional meetings with locally driven agendas to enhance resource use and improve local information for contacts in areas of cultural competence.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75	75	75	75	75
Annual Indicator	46.5	46.5	46.5	46.5	45.1
Numerator					
Denominator					
Data Source		2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey	2009-10 CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	75	75	75	75

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

a. Last Year's Accomplishments
In FY11, working with CCNC, the C&Y Branch helped design and implement a new statewide system of care coordination through LHDs closely aligned with medical homes known as CC4C. C&Y Branch staff also continued to work with and provide technical assistance to school health centers and LHDs to enhance their coordination and communication with medical homes or to serve as medical homes.

The C&Y Branch developed and began implementation of a statewide training and technical assistance plan (which included purchasing the Bright Futures Tool and Resource Kit) for all LHDs to implement Bright Futures guidelines using quality improvement approaches and tools to enhance delivery of preventive services in LHDs to increase coordination and communication with medical homes.

Additional activities undertaken by the C&Y Branch to increase and improve the use of medical homes included:
-worked with the NC Pediatric Society (NCPS), CCNC and other partnering agencies to increase the number of National Committee on Quality Assurance recognized patient centered medical homes in LHDs and in private practices;
-supported and participated in specific efforts with CCNC, NCPS, and LHDs related to the state's CHIPRA grant to improve services delivered by medical homes for CSHCN using a learning collaborative model involving about 12 private practices and LHDs;
-worked to improve timely re-screening, follow up, and referral of abnormal newborn hearing and metabolic screening results;
-worked to enhance and support the planning and implementation of needed care and communication about specific roles in the care for the infant/child after he/she is identified as hearing impaired/deaf in partnership with medical homes, families, LHDs, audiologists, ENTs, CDSAs, and social services (especially for home and out of state births and adoptions);
-began implementation of a March of Dimes grant to create care plans for CSHCN, especially those with genetic conditions, and to develop materials to empower the family to find and use a medical home for their child;
-continued to enhance the capacity to address the social-emotional development of infants and children from birth to 8 years of age in the medical home (mental health consultants) and to enhance the community supports (ABCD pilot) and availability of evidence based home visiting (i.e., Nurse Family Partnership [NFP]) and parenting programs (Triple P) available in communities for medical homes to use with their patients and families through the Linking Actions to Unmet Needs in Child Health (LAUNCH) grant and other C&Y Branch efforts at a local and state systems levels;
-supported implementation of several of the recommendations of the Special Care Dentistry Report through the CHIPRA grant to assist medical homes to address oral health especially for CYSHCN;
-provided input on disabilities as a new member of the Women's Integrated Systems for Health (WISH) Technical Assistance Expert Panel to help advance integrated systems which include access to and use of a medical home that promote mental and physical health for women of childbearing age including YSHCN;
-supported the Pregnancy Medical Home efforts with DMA, CCNC, and LHDs to improve the health of women during pregnancy;

-posted medical home related data on the NCDOH website and helped the NC SCHS develop several Child Health Assessment Monitoring Program (CHAMP) reports that include data related to medical home for CYSHCN;
-used medical home data to develop the NC Plan to Promote Health of People with Disabilities;
-participated in the Teen Prevention Education Program conference;
-supported the four IA counties to work closely with UNCG to build effective CSHCN family and community steering committees and to construct logic models and action plans to identify and address community system changes to improve the health of CSHCN and their access to care through medical homes;
-continued to work with the NCPS to look for opportunities to update and implement some of the Foster Care Medical Home Collaborative recommendations;
-worked with medical homes and families to assure that timely decisions were made about requests for a variety of different medical and mental health services for CSHCN served by Health Choice and Medicaid; and
-worked with DMA to help with the transition of the NCHC program to Medicaid in partnerships with medical homes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Educate the families of children enrolled in HC and NCHC, other community agencies, and other providers on the importance of a medical home.				X
2. Support systems of care that assure children are screened early and often for special health care needs.				X
3. Maintain a toll free Help Line for referral of CSHCN to appropriate programs, services and providers.		X		
4. Participate in discussions and presentations related to the patient centered medical home with primary care providers and their state professional organizations.				X
5. Widely disseminate educational information and materials developed specifically for increasing medical home awareness with parents of CSHCN.			X	
6. Support systems of care that assure CSHCN have access to and are linked with a medical home.				X
7. Support transition as part of care provided in the medical home in the form of self-management of chronic disease and planned transfer to adult health care.			X	
8. Use, analyze, and promote data on CSHCN to inform efforts related to the promotion of the importance of a medical home.				X
9. Support and promote the development of family-professional partnerships.				
10.				

b. Current Activities

The C&Y Branch continues to analyze and disseminate state and national data related to access to and use of a medical home for CSHCN to increase awareness about and use of a medical home. Branch staff updates and disseminates medical home related materials and web site information developed for families by the NC Healthy Start Foundation, CCNC, the IA sites, and within the Branch. The CSHCN Help Line continues to be promoted as a statewide resource for clients, families and medical home providers. In addition, staff members are promoting the medical home approach for implementation of the national Bright Futures guidelines for all CYSHCN with LHDs and CCNC. They are also working to increase knowledge and use of all EPSDT services for CSHCN with Medicaid in coordination with a medical home.

Working with LHDs, the NCPS, and CCNC, C&Y Branch staff members are exploring ways to use an electronic health record to enhance the abilities of providers to care for CYSHCN. They are continuing to improve the CC4C program's collaboration and communication with the child's medical home and enhancing coordination with quality medical homes for children in foster care.

The C&Y Branch is providing continued financial and technical assistance support to IA pilot projects. They are also supporting implementation of the NC Plan to Promote the Health of People with Disabilities that addresses many needs including receiving quality care within a medical home.

c. Plan for the Coming Year

In FY13, the C&Y Branch plans to continue working with LHDs and CCNC to systematically increase the capacity of medical homes to screen, identify and coordinate care for social-emotional developmental concerns and conditions. Staff members will continue working with NCPS, CCNC, and the IA sites to address transition of YSHCN to adult health care within the context of a medical home. The will also continue to assist LHDs and CCNC medical home providers with questions and provide technical assistance about a variety of services for CSHCN related to hearing screening, nutritional therapies, newborn screening, etc.

C&Y Staff members will continue participation in the CHIPRA Oral Health Workgroup to ensure the dental needs of CSHCN can be met through coordination with the medical homes, dental providers and families. As a result of the recommendations from the Special Care Dentistry Report, the Commission on CSHCN continues to have a dentist serve as an active member. The Commission's Oral Health for CSHCN Workgroup collaborates with NCODH on dental accessibility tools and education for patients and providers in the state.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	80	80	80	80
Annual Indicator	63.7	63.7	63.7	63.7	58.5
Numerator					
Denominator					
Data Source		2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey	2009-10 CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	80	80	80	80	80

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure.

a. Last Year's Accomplishments
According to the 2009-10 National Survey of CSHCN, 36.3 % of CSHCN in NC were reported to be currently insured but their insurance was inadequate; this is slightly higher than nationwide rate which was 34.3%.

2007-2009 CHAMP data was used to create a series of fact sheets related to children's health care coverage. Fact sheets were created for those children enrolled in Medicaid and Health Choice and also looked at special needs status.

LHDs continued to work to assure CSHCN enrolled in Medicaid or Health Choice to help pay for services and medications that were needed and to help families access additional resources when public or private insurance was not adequate.

The C&Y Branch continued involvement with the Physician's Advisory Group (PAG) process related to the development, elimination, and/or review of clinical policies and services for Medicaid CSHCN and now for NCHC CSHCN.

The Commission's Oral Health Workgroup continued to partner with the Special Care Dentistry Advisory Group, the Family Council, and NCODH to promote access to oral health care for CSHCN. The Commission added a Governor-appointed dentist who has served CSHCN on public insurance to its membership.

The CSHCN Help Line provided information to families and health care providers of CSHCN on available insurance programs. The Help Line Report has been condensed and disseminated to a wider audience and is used to assess trends in service needs and inform discussions about adequacy of service coverage for CSHCN. The Help Line continued to promote the availability of insurance for CSHCN through Inclusive Health Care's High Risk Insurance Program.

EHDI consultants and genetic counselors continued to assist families of CSHCN to access their public or private insurance for recommended services and testing.

Branch staff monitored CSHCN enrolled in SSI/Medicaid monthly and contacted their families to make sure that they could access Medicaid available services.

Minority outreach to families of CSHCN was provided through a Latina staff member (bilingual-bicultural) who successfully focused on populations that are hard to reach. She cultivated key contacts in the communities representing Hispanic, American Indian, African American, and newly resettled refugee populations from Southeast Asia and Africa. She frequently collaborated with ECAC, National Alliance on Mental Illness/NC, and Autism Society Latino Support Group families in efforts to serve Latino children.

CC4C care managers through the LHDs will work with families of CSHCN eligible for Medicaid, NCHC and/or private insurance to help assess their needs and access services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain Health Check/NC Health Choice (HC/NCHC) Outreach Campaign in coordination with the NC Healthy Start Foundation, DMA, State Employees Health Plan and DMH/DD/SAS.			X	
2. Maintain NC Family Health Resource Line as a bilingual informational telephone hotline.			X	
3. Continue to expand HC/NCHC Outreach web site.			X	
4. Continue to expand HC/NCHC educational campaign regarding medical home/ER use/preventive care.			X	
5. Simplify enrollment/re-enrollment forms and develop/disseminate family-friendly notices.		X		
6. Develop comparable data sets for HC and NCHC.				X
7. Target outreach to special populations (including minority and CSHCN).			X	
8.				
9.				
10.				

b. Current Activities

DMA and C&Y Branch staff are working to ensure that services for CSHCN continued while transferring the NCHC Program to DMA. The current Medicaid claims processor, HP, assumed claims payment responsibilities for NCHC in October 2011.

The Commission for CSHCN members and Branch staff continue to provide expertise and recommendations to revise and strengthen current medical and behavioral health services for CSHCN eligible for Medicaid and NCHC.

C&Y Branch staff collaborated with DMA on its joint three-year contract with a behavioral health utilization review vendor for Medicaid and NCHC CSHCN, which ended in September 2011. The new contract was assumed by DMA to serve Medicaid and HC children. The vendor continues to participate in Commission workgroups and meetings.

The CSHCN Help Line staff provides information to families and health care providers of CSHCN on available insurance programs.

Minority outreach to families of CSHCN who are difficult to reach continues to be provided. Co-presentations continue with ECAC, National Alliance on Mental Illness/NC, and Autism Society Latino Support Group families to Latino families of CSHCN.

The C&Y Branch provides support to many school-based and school-linked health centers that provide comprehensive medical services to adolescents. Services are billed to Medicaid or

private insurances, but not to families.

The LAUNCH and IA grantee counties continue to focus on increasing community capacity to serve young children and CSHCN.

c. Plan for the Coming Year

The Commission for CSHCN will stay abreast of Health Care Reform developments and implications as they impact CSHCN in NC and will provide ongoing feedback and recommendations to NC leaders to ensure children have access to health insurance. Commission members and staff will continue to participate in DMA/DMH Clinical Policy Workgroups and other appropriate groups. The Commission's Behavioral Health Workgroup will monitor claims paid data for behavioral health services for Health CSHCN to determine changes in utilization trends. The Commission's Oral Health Workgroup will continue to partner with the Special Care Dentistry Advisory Group, the CHIPRA Oral Health Workgroup, the BFP, and the NCODH to promote access to oral health care for CSHCN.

The CSHCN Help Line staff will continue to provide information about insurance eligibility for Medicaid and NCHC and about coverage for needed services. Staff will also continue to promote the availability of insurance for CSHCN through Inclusive Health Care's High Risk Insurance Program.

C&Y Branch staff will continue to work with DMA and the PAG to assure that services in Medicaid and NCHC are adequate to meet the needs of CSHCN

EHDI consultants will continue to educate and provide support to families of children needing a rescreening or diagnostic procedure related about how their private insurance or Medicaid covers these and other needed hearing related services.

Minority outreach to families of CSHCN will continue to be provided through a Latina staff member (bilingual-bicultural) focusing on populations that are hard to reach. She will continue to cultivate key contacts in these communities representing Hispanic, American Indian, African American, and newly resettled refugee populations from Southeast Asia and Africa. A special grant from AMCHP selected NC to lead an Action Learning Collaborative to focus on improving services and access to services for Latino/Hispanic families with CYSHCN. The C&Y Branch Minority Outreach Coordinator will work with the Latina Health Educator from ECAC (statewide) and five Autism Society of NC Latino Support Group facilitators to lead the collaborative in partnership with AMCHP and the National Center for Ease of Use of Community-Based Services. Webinars and a site-visit to one of the partnering states of the Action Learning Collaborative (IN, NH, NM, OR, and RI) will help to identify successful services to Latino/Hispanic families with CYSHCN and provide future steps to better serve all limited-English Proficient families.

Outreach is being planned to families about EPSDT provisions, with respect to coverage of medically necessary services. This will be coordinated by non-profit agencies, NCODH, and DPH, in partnership with DMA.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	90	90	90	90	90

Annual Indicator	89.3	89.3	89.3	89.3	70.3
Numerator					
Denominator					
Data Source		2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey	2009-10 CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90	90	90	90

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

a. Last Year's Accomplishments
An environmental scan to determine current capacity for early childhood services for children up to 8 years was completed in Guilford County and at the State level as part of the Linking Actions to Unmet Needs in Child Health (LAUNCH) grant project sponsored by SAMSHA. The LAUNCH project developed a plan to address the identified community and state gaps in services and systems operations identified by this scan which included placing teams of mental health coordinators and family partners in practices and community agencies to assist families of CSHCN access services in the community.

A newly designed care coordination system and population management model was implemented March 1, 2011 for CSHCN under five years. The former Child Service Coordination

(CSC) program was transitioned to the Care Coordination for Children (CC4C) program in partnership with Community Care Networks and LHDs to target the highest risk and highest cost children for care management. Each medical home serving children birth to age 5 years was assigned a specific CC4C Care Manager(s) to work with their clients. Payment changed from a fee for service to a per member per month model for Medicaid eligible children. DMA also began a Pregnancy Medical Home program and offered incentives to obstetricians to join the CCNC network and provide medical homes for pregnant youth and women, especially those with chronic conditions. Branch staff continued to send letters about birth to five year old CSHCN who applied for SSI benefits to LHDs who offer assistance to these families with care coordination through the CC4C program. A separate school nurse case management system for CSHCN was improved and expanded from the eastern part of the state and is voluntarily being implemented in more counties in the State.

$2.1 million of ACA grant funding was available to implement a coordinated home visiting program in NC. A Request for Applications (RFA) was developed to solicit applications for the 4 models NC chose to support: Early Head Start, NFP, Healthy Families, and Parents as Teachers. Planning and recruitment for a Governor's Early Childhood Advisory Council began. The Council has been charged with assuring that NC has an effective and efficient system of services for young children. A sub group of the Council serves as the Advisory Board for the Home Visiting program.

The legislated NC IOM Task Force on Mental Health, Social, and Emotional Needs of Young Children and their Families began in March 2011. One of the charges to this Task force is to "identify strategies to ensure that children who are at high risk of developing mental health problems and their families have access to a comprehensive range of treatments and services, coordinated across agencies and service systems. The Title V Director is serving as a member of the Task Force.

Community services offered by the State were continued including Child Care Health Consultants to improve access to local child care centers, Regional EHDI Consultants for follow-up newborn hearing screening, and Genetic Satellite clinics in specific counties to increase accessibility to these very specialized services.

The CSHCN Help Line continued to provide information and referrals to families despite a reduction in staff for coverage. The individual in the position was approved for extended medical leave and this responsibility was combined with the FLS position for temporary and ongoing coverage. Information from callers related to service needs, barriers to accessing services, and trends about use of the Help Line continued to be compiled and shared with Branch members, the Section, appropriate committees and workgroups and the Commission on CSHCN.

A Hearing Health Care Map was developed by parents and distributed to parents whose infants did not pass their hearing screening. The information helps guide parents through the screening process.

A single point of entry referral process was implemented, expediting referrals to EI services. Parents sign a release at the time of diagnosis allowing the EHDI program to share their information with EI, Beginnings and the Deaf and Hard of Hearing program.

The IA counties continued to work on implementing effective and organized community-based systems of care strategies for CSHCN. Examples of system changes include improvement in data sharing, facilitation of referrals, a strong increase in parent leadership, increased psycho social screening, and improvements in care management.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Support conversion of the Child Service Coordination Program to CC4C.		X		
2. Continue provision of Early Intervention services and implementation of system design changes.	X			
3. Continue UNC CSHS Clinics	X			
4. Continue CSHCN Help Line.		X		
5. Continue training child care for children who are medically fragile.				X
6. Continue to advocate for additional school nurses and provide education and training to enhance their intervention skills in work with CSHCN.				X
7. Develop infrastructure to support transition services.				X
8.				
9.				
10.				

b. Current Activities

A full day meeting for family advisors and C&Y staff was held to discuss family's interests, roles, ideas and program linkages. A CLAS Summit (minority outreach) was hosted by C&Y to integrate staff more closely with resources for minority populations, community based services and systems in NC. Methods for enhancing contact with minority populations, appropriate trainings and family involvement in this area were examined and methods for improvement were identified.

A replication guide to enhance community based systems of care for CSHCN is being created by UNC Greensboro as part of the IA project and will be shared with counties across the state. Participating counties are comparing lessons learned and areas of progress for replication across sites where appropriate.

The CSHCN Help Line assists families in accessing needed services, and Triple P programs in seven counties were initiated to improve access to care for families and CSHCN. The highest needs in counties are around prevention or intervention in social emotional areas of health for all ages of children, including early childhood. Triple P offers an evidence based intervention for the population in implementing counties. School nurse case management and CC4C services were expanded during the year to reach additional children. A learning collaborative in Alamance County for Attachment Behavioral Catch Up therapy training will further enhance early childhood mental health services for several counties.

c. Plan for the Coming Year

The Branch will consider replication of lessons learned from community grants for CSHCN and plan to expand IA and Triple P and will implement a newborn home visiting program based on "Durham Connects," a promising program for new mothers and their infants. The new program will be offered in 1-3 additional counties under the Early Learning Challenge grant funding in the northeastern part of the State. The program provides possibilities as an effective county triage system for early childhood services, too.

Providers who serve pregnant women and children will be offered the year long Motivational Interviewing training next year if one time funds are available. The training was opened to school nurses, Child and Family Support Team social workers and nurses, home visitors, LHD staff in maternity and child health, and others as slots permitted. The C&Y Branch hopes to expand to other child serving providers next fiscal year to enhance the services provided to families of CSHCN. The possibility of training school nurses and other child service providers in Mental Health First Aid is also being assessed. It is an evidenced informed consensus practice that provides good support to the community at large and fits in the community based continuum of

mental health promotion and prevention/suicide prevention and early intervention.

As reported earlier, the CSHCN Help Line responsibilities have been combined with the FLS responsibilities. The Branch is in conversation with families of CSHCN to co train as backups for the Help Line. They would be paid out of the contract for family services. The CSHCN Help Line will continue to provide information and support to families of CYSHCN and provide quarterly reports to the Commission on CSHCN. Help line staff work closely with multiple partners, including DMA and SCHIP staff, to assist callers in identifying solutions to their requests.

The Hearing Health Care Map, developed by parents, will be printed in Spanish for families whose infants do not pass their hearing screening to guide them through the EHDI process. The teleaudiology project will continue in 36 rural eastern counties where access to audiologists providing these services is very limited. The initiative will continue to use an established telemedicine network of 7 remote sites in the eastern part of the state.

In consideration of the Life Cycle approach, effective systems improvements, and a focus on evidence based programs and implementation science, there is a great deal of interest in preparing counties to effectively increase their skills and readiness for using this information in their planning, implementation and evaluation of initiatives. The C&Y Branch is considering a series of regional training sessions for LHDs and community partners using resources such as the National Implementation Research Network (NIRN), BUILD Initiative, and the Finance Project to work with local providers during the upcoming year.

Ongoing activities will continue.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5.8	45	45	45	50
Annual Indicator	39.9	39.9	39.9	39.9	43.7
Numerator					
Denominator					
Data Source		2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey	2009-10 CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	50	50	50	50

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

a. Last Year's Accomplishments
C&Y Branch staff disseminated and promoted transition information (which includes the Carolina Health and Transition [CHAT] materials) with state professional organizations, health care providers, families, community based agencies and school nurses. NCODH and Mountain Area Health Education Center (MAHEC) both post the CHAT materials on their websites.

The Branch PMC presented at several conferences and meetings to promote enhanced transition efforts with YSHCN as part of the care that youth should receive within medical homes.

The NCODH hosted an expanded meeting of their advisory committee to focus on reviewing and discussing current transition efforts across the state with key stakeholders. This included an update from the CHAT partners on the status of their work, resources, and state and national initiatives related to transition.

C&Y Branch staff assisted with planning the second annual Health Care Transition Conference and continued to participate in the NC Health Care Transition Research Consortium (HCTRC) listserv and monthly conference calls.

The four IA grantees continue to distribute CHAT guides to families and providers; assess county level needs to assist pediatric providers in securing adult medical homes for their patients; promote the use of transition checklists to help families/youth develop skills and knowledge to successfully transition to adult systems of care; and seek ongoing feedback about transition issues from parent advisory groups and transition committees.

The newly developed NC Plan to Promote the Health of People with Disabilities includes a focus on YSHCN and life transitions.

Regional genetic counselors provided information on transition during genetic counseling sessions and in follow-up letters and phone calls. Counselors also provided presentations to

family support groups to help families learn what to expect in the future for their CSHCN and the available options.

C&Y Branch staff consulted with families of CYSHCN who were eligible for SSI about family questions or concerns related to transition services as youth move from pediatric to adult health care.
C&Y Branch staff participated in promoting transition in CHIPRA Connect efforts through CCNC.

The Health Check Billing Guide for all Medicaid preventive services for children and youth included the need to plan for and address transition for youth.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide a greater focal point for transition, by diffusing transition responsibilities across the C&Y Branch and by inserting transition linkage responsibilities into job descriptions.				X
2. Continue training and TA to YSHCN, families and providers.				X
3. Provide TA on youth leadership development and access to health care to the NC Developmental Disabilities Council.				X
4. Collaborate with the School Health Program and other WCHS planning bodies, to include youth with disabilities in an advisory capacity for Title V programs.				X
5. Promote transition as a focus in planning for medical homes for CSHCN.				X
6. Continue to use the National Survey of Children with Special Health Care Needs data in planning transition efforts and galvanizing support.				X
7. Continue participation in the DHHS Eliminating Health Disparities Initiative.				X
8. Collaborate with provider associations, and other Departments to support transition.				X
9.				
10.				

b. Current Activities
Some of the many activities that C&Y Branch staff members are involved in to promote better transitions to adult life for YSHCN include:
-improving systems-level processes to transition YSHCN from pediatric to adult health care through the IA grants;
-working with MAHEC to include information on transition of YSHCN in MAHEC's educational activities for health care providers;
-working with ECAC and the Family to Family Health Information Network to educate families;
-participating in NC HCTRC to promote best practices with state and national stakeholders;
-working with LHDs on transition of YSHCN within Bright Futures and medical home context to assure preventive, acute and chronic health care for children and youth who transition to adult care;
-promoting transition strategies in school health centers; and
-providing resources and referrals on transition from pediatric to adult care through the CSHCN Help Line.

The NCODH has developed materials on transition to adulthood and the prevention of rape and sexual assault for young adults with disabilities. They use these materials in workshops with youth, families and agencies. The NCODH is surveying residential providers on their capacity to

provide sexual assault prevention services to youth and adults with intellectual disabilities and is analyzing results of a survey of community-based sexual assault agencies on their capacity to serve clients with intellectual disabilities.

c. Plan for the Coming Year

In FY13, the C&Y Branch staff members will continue to work to enhance transition efforts. They will work with the medical homes participating in the NC CHIPRA Connect project. The CHSNC Help Line staff member will continue to provide resources and referrals to families of children transitioning from pediatric to adult systems of care. IA grantees will continue to work to improve how systems of care in their local communities address and support the transition of YSHCN to all aspects of adult life. The NCODH will continue to support transition as a focus area in its work with CYSHCN in their access to care, health promotion, and emergency preparedness efforts. The Branch PMC will continue to work with the NCPS, LHDs, the North Carolina Academy of Family Physicians and other health care provider agencies to promote transition efforts at academic medical centers, LHDs, and private practices across the state.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	82.4	75.1	80.5	81.7	79.5
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90	90	90	90

Notes - 2011

Data are from the National Immunization Survey for the Q3 2010 to Q2 2011 time period (July 2010 to June 2011). As this is a weighted estimate, data for the numerator and denominator are omitted.

The NIS data released in April 2012 for the June 2009 to July 2010 time period excluded Hib in the 4:3:1:3:3:1 measure (4:3:1:0:3:1) to allow for an equitable measure despite the Hib shortage or Hib product being used. The WCHS has chosen to continue to use the 4:3:1:0:3:1 measure as its indicator as it provides a more accurate assessment of vaccine coverage, particularly as the CDC is moving towards including both Varicella (1 dose) and Prevnar (4 doses) in the performance measure series. NC does not require Prevnar. Hib will continue to be excluded from measures through calendar year 2012 to provide an equitable measure despite the Hib shortage.

Notes - 2010
Data are from the National Immunization Survey for the Q3 2009 to Q2 2010 time period (July 2009 to June 2010). As this is a weighted estimate, data for the numerator and denominator are omitted.

The NIS data released in March 2011 for the June 2009 to July 2010 time period excluded Hib in the 4:3:1:3:3:1 measure (4:3:1:0:3:1) to allow for an equitable measure despite the Hib shortage or Hib product being used. A measure excluding Hib for the 4:3:1:3:3 series was not provided. NPM#7 does not include varicella , but it is included in the NIS data.

Notes - 2009
Data are from the National Immunization Survey for the Q3 2008 to Q2 2009 time period (July 2008 to June 2009). As this is a weighted estimate, data for the numerator and denominator are omitted.

The NIS data released in May 2010 for the June 2008 to July 2009 time period excluded Hib in the 4:3:1:3:3 measure (4:3:1:0:3) to allow for an equitable measure despite the Hib shortage or Hib product being used.

a. Last Year's Accomplishments
In June 2010, the Universal Childhood Vaccine Distribution Program (UCVDP) was discontinued due to a state budget shortfall. The state legislature cut all state funds to provide vaccines to the privately insured population which is approximately 33% of the children in the state. The newly named North Carolina Immunization Program (NCIP) will continue to provide vaccine at no cost to qualified children through the federally funded Vaccines For Children (VFC) program.

During FY11, contracted statewide deployment of the North Carolina Immunization Registry (NCIR) was completed, and 95% of NCIP providers are now using the NCIR. Increased provider participation in the NCIR will help to ensure that client immunization histories documented in the NCIR are complete. A program evaluation project completed in 2010 which assessed the effectiveness of reminder/recall training showed an increase in the use of reminder/recall by providers and an increase in coverage rates per provider among those who had received the training. Immunization Branch (IB) staff members will continue to train providers on the utilization of NCIR reminder/recall tool during VFC site visits and Assessment, Feedback, Incentive, and eXchange (AFIX) visits.

The National Immunization Survey (NIS) childhood immunization coverage rates released in April 2012 for the July 2010 to June 2011 time period excluded Hib in the 4:3:1:3:3:1 measure (4:3:1:0:3:1) to allow for an equitable measure despite the Hib shortage or Hib product being used. NC's rate was 79.5% with a ranking of 18th among the states and the District of Columbia. Additional NIS data for the January to December 2010 time period for the 4:3:1:3:3 measure was released in May 2012 via an email from the MCHB. NC's rate was 78.5% with a ranking of 15th among the states and the District of Columbia. The WCHS has chosen to continue to use the 4:3:1:0:3:1 measure as its indicator, however, as it provides a more accurate assessment of

vaccine coverage, particularly as the CDC is moving towards including both Varicella (1 dose) and Prevnar (4 doses) in the performance measure series. NC does not require Prevnar. Hib will continue to be excluded from measures through calendar year 2012 to provide an equitable measure in light of the Hib shortage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintenance of the Vaccines For Children Distribution Program.			X	
2. LHD assessment and tracking activities.				X
3. Complete at least 650 VFC/AFIX visits in calendar year 2012.				X
4. Update the Immunization Branch web site as necessary.			X	
5. Continue development of a bidirectional interface for the immunization registry.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The number of VFC site visits and AFIX visits increased in FY12 with the new CDC requirement that 50% of NCIP providers receive a VFC site visit each year. NCIP staff members will continue to train providers on the utilization of NCIR reminder/recall tool during VFC site visits and AFIX visits. Greater use of these tools by providers should help to increase the overall completion rate of the 4:3:1:3:3:1 series in NC. In addition, inventory management training will be provided to all new NCIR providers at the time of deployment. The IB completed its contract with Better World Advertising vendor to develop Public Service Announcements (PSAs) with messages to parents about the immunizations their children need. PSAs were designed to target various age groups. The firm also developed billboards and print graphics.

The IB hosted its state immunization conference. Workshops were conducted by IB staff and guest speakers to raise the awareness of childhood immunizations, improve accountability, and effectively use the NCIR as a reminder/recall tool.

c. Plan for the Coming Year

During FY13, the number of AFIX visits should continue to increase. A program evaluation project completed by the IB verified the effectiveness of Webinar training as part of the AFIX program in lieu of an in-person site visit. Childhood AFIX visits may begin to utilize the webinar tool to increase the number of visits.

The IB will be conducting regional NCIR workshops on provider accountability. Although the connection may not seem obvious, improved provider accountability can lead to higher coverage rates as it helps to ensure complete client records and improves the effectiveness of the reminder/recall function.

The IB retained ownership of all media items, including PSAs developed during FY12. If funding allows, the branch will launch another awareness campaign during FY13.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	26	24	24	24	22.5
Annual Indicator	24.6	26.6	25.1	22.9	19.9
Numerator	4306	4775	4730	4193	3702
Denominator	175313	179620	188698	182941	185570
Data Source		NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	19	19	18.5	18.5	18

Notes - 2011
The data source for the numerator is vital records as reported in the Basic Automated Birth Yearbook for 2010 on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

FY year data are actually the prior calendar year, e.g. FY11 is really CY10.

Notes - 2010

The data source for the numerator is vital records as reported in the Basic Automated Birth Yearbook for 2008 on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

FY year data are actually the prior calendar year, e.g. FY10 is really CY09.

a. Last Year's Accomplishments

Through the Teen Pregnancy Prevention Initiatives (TPPI), the NC DHHS invests in the young people of North Carolina by helping them gain the knowledge and skills they need today so they will be able to take care of themselves, their families, and their communities for the rest of their lives. TPPI provides four-year competitive grants to local agencies including public health departments, county departments of social services, school systems, and private non-profit agencies to prevent teen pregnancy and support teen parents.

The Adolescent Parenting Program (APP) helps teen parents prevent a subsequent pregnancy, graduate from high school, go on to post-secondary education or training, and improve the developmental outcomes for their children. The program is implemented by at least one full-time coordinator with a caseload of 15-25 first-time teen parents. Through individualized goal plans, intensive case management services, and group educational sessions, program participants are empowered to become self-sufficient and build a better future for their babies.

Only 12, or 1.5%, of the 786 teen parents enrolled in APP in FY11 had a repeat pregnancy, while the overall repeat pregnancy rate among teens in North Carolina is 27.0%. In addition, while parenthood is the leading cause of school dropout among teen girls in the U.S., the dropout rate among APP participants was 3.82%, which only slightly higher than the dropout rate among the general student population in North Carolina in SY11 (3.43%). More than three-fourths (76.3%) of the 164 APP graduates reported plans to enroll in post-secondary education, vocational training, or the military. In 2010, reports of abuse or neglect were filed on 4.61% of children ages 0-5 in North Carolina. During FY11, local APP coordinators reported that none of their participants had open cases with Child Protective Services (CPS). Follow-up discussions with local APPs indicated that coordinators are not always aware of all CPS reports; therefore, relying on coordinators to accurately report cases of child abuse or neglect has significant limitations.

The Adolescent Pregnancy Prevention Program (APPP) prevents teen pregnancy by providing young people with essential education, supporting academic achievement, encouraging parent/teen communication, promoting responsible citizenship, and building self confidence among participants. Local agencies that are awarded pregnancy prevention funds are required to implement programs that have been shown through evaluation to be effective at reducing teen pregnancies. FY11 program evaluation revealed that APPP participants demonstrated increased knowledge, attitudes, and beliefs that support a delay in sexual activity or sexual risk reduction. Participants also reported feeling more comfortable discussing sexual health issues with their parents, and there was a corresponding increase in reported parent-teen communication. Sexually active participants reported increased condom use at last intercourse, and a greater percentage of sexually active participants reported that they "always" use a contraceptive method when they have sex.

Through the 29 APP and 29 APPP programs in 41 of the 100 North Carolina counties, approximately 7,653 young people between the ages of 10 and 19 in the state were served during FY11.

The teen birth rate in North Carolina continues to decline. In 2010, the birth rate for teenagers aged 15 through 17 years reached an all-time low of 19.9/1,000. This is a decline of 25% from the 2005 rate of 26.7/1,000.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing support provided for Teen Pregnancy Prevention Initiative projects.		X		
2. Primary prevention projects participate in annual evaluation process.				X
3. All TPPI projects participate in a web-based process evaluation program.				X
4. Annual Teen Pregnancy Prevention Symposium (with the Adolescent Pregnancy Prevention Campaign of NC).				X
5. Annual Adolescent Parenting Graduation Conference.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, 29 APPs and 29 APPPs are funded in 41 North Carolina counties. Year-to-date, APP and APPP have served 540 and 3,086 participants, respectively.

Improving the evaluation of both APP and APPP remains a focus area for TPPI. A web-based process data collection system was introduced in FY12, which includes improved reporting features that allow for a more thorough assessment of whether projects are meeting their scope of work objectives.

After conducting a training needs assessment, TPPI provided training on the Partners for a Healthy Baby home visiting curriculum in March 2012. As a result, all APPs are currently trained to implement an evidence-based home visiting curriculum. Curriculum fidelity is a focus area for APPP. In the Spring of 2012, TPPI partnered with the University of North Carolina at Chapel Hill's Gillings School of Global Public Health to determine barriers experienced by local APPPs in implementing their chosen curriculum with fidelity. TPPI will use the results of this effort to provide improved technical assistance to APPP.

NC DHHS submitted an RFA in response to the Administration for Children and Families' Personal Responsibility Education Program (PREP) formula grant, and was awarded $1.54 million each year over five years. TPPI administered these funds through a competitive RFA; ten grantees from high-need counties were awarded funding for FY12. Year-to-date, PREP has served 520 participants.

c. Plan for the Coming Year

The outcome evaluation plan for the APPP will continue to be improved in an effort to establish the efficacy of these primary prevention programs. Continued opportunities for evaluation capacity-building will be made available to APPPs and will cover topics such as survey administration, comparison group recruitment and fundamentals of data analysis. Plans also include focus groups with participants of local APPPs, which will provide useful qualitative data to supplement quantitative findings.

As noted above, there are significant shortcomings in the APP's child maltreatment data collection process. During FY11, local APP coordinators reported that none of their participants had open cases with CPS. Follow-up discussions with local APPs indicated that coordinators are not always aware of all CPS reports; therefore, relying on coordinators to accurately report cases of child abuse or neglect has significant limitations. To better capture child abuse/neglect reports

on APP participants, a data sharing agreement with Division of Social Services will be pursued. In addition, DHHS will continue its partnership with RTI International in an effort to secure funds for a larger-scale evaluation of APP. Aims of the evaluation are to substantiate APP's effectiveness in improving outcomes for both teen parents and their children.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	50	50	50	50	50
Annual Indicator	42.0	45.0	44.0	44.0	44.0
Numerator	36285	36234	37835	34740	34740
Denominator	86393	80521	85988	78954	78954
Data Source		DPH Oral Health Section Surveillance System	DPH Oral Health Section Surveillance System	DPH Oral Health Section Surveillance System	DPH Oral Health Section Surveillance System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	50	50	50	50

Notes - 2011
Due to incomplete development of a new database in the Oral Health Section, data for school year 2011 are not available at this time. Therefore, school year 2010 has been repeated here.

These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

Notes - 2010

Due to incomplete development of a new database in the Oral Health Section, data for school year 2010 are not available at this time. Therefore, school year 2009 has been repeated here.

These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

Notes - 2009
These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

a. Last Year's Accomplishments
Data on dental health status for FY11 are not yet available. During the 2009-10 school year, data was collected on 78,954 fifth grade school children (69%). The proportion who had dental sealants was 44 percent. During FY11, as part of state supported sealant promotion projects, and using a small supplement from Preventive Health and Health Services Block Grant funding, the Oral Health Section (OHS) provided 5,733 sealants for 1,512 children during 24 sealant projects.

During the past two years, the OHS has been working on a major change in the reporting system that collects data on the children screened. They have worked with the NC Department of Public Instruction to develop a system to download classroom rosters which contain demographic data on the children. The system has been fully developed, but logistical challenges in implementation, coupled with staff losses, have delayed the analysis of the last two years' data. Preliminary reports on data for the 2009-2010 school year have just been received. Reports by race/ethnicity are being finalized. Data from the 2010-2011 school year should be available shortly.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide dental assessment of oral health status conducted in alternate school years (even years).			X	
2. Staff driven and community-based sealant projects conducted.	X			
3. Educational services provided in various settings.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In FY12, the OHS is once again focusing on providing dental sealants for school children at high-risk for dental decay. Over the years, funding from the Preventive Health and Health Services

Block Grant has decreased by 70%, plus state appropriations for the Oral Health Section's operations have decreased. In the last couple of years, the OHS has lost 12 Public Health Dental Hygienist positions, one of the three dental equipment technicians that set up the sealant projects, and the single stock clerk position that supported the entire state program. The loss of staff leaves staff distributed less densely, decreasing the number and location of sealant projects, and increasing the cost of the projects, both in staff time and travel. Dental sealant projects continue, but at a reduced level. If there are no further reductions in staff or funding this summer, the OHS hopes to provide approximately 5,000 sealants.

c. Plan for the Coming Year

Assuring that children at high risk for tooth decay get dental sealants continues to be one of the OHS's top priorities. Preventive Health and Health Services Block Grant funds were eliminated, but we have been told that our portion may be reinstated. Getting parental permission for their children to get sealants is increasingly difficult. This problem does not seem particular to sealants, but just that communication between schools and parents is getting more and more difficult - permission slips are sent home, but never seen by parents or returned to school by the children. There could also be growing concern regarding patient information and the desire for privacy. Even with these barriers, however, OHS hopes to continue to provide sealants to those children at highest risk. Due to the loss of staff (both public health dental hygienists and a dental equipment technician) and operating funds, the projected number of sealants to be placed is 4,000.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	4.5	4.5	4	3	3
Annual Indicator	5.0	4.0	3.0	3.1	2.8
Numerator	90	73	54	58	54
Denominator	1788230	1823562	1829372	1844706	1899089
Data Source		NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.7	2.7	2.7	2.7	2.7

Notes - 2011
Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

Data are for the calendar year preceding the fiscal year (2011 data are for CY2010).

Notes - 2010
Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

Data are for the calendar year preceding the fiscal year (2010 data are for CY2009).

Notes - 2009
Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

Data are for the calendar year preceding the fiscal year (2009 data are for CY2008).

a. Last Year's Accomplishments
Motor vehicle deaths of children continued to decline, with a 7% decline in numbers overall from 2009 to 2010. The 2010 rate of children younger than age 15 dying in motor vehicle crashes (MVCs) was 2.8 per 100,000 children.

Collaborative and complementary efforts continued among the Injury and Violence Prevention Branch (IVPB), NC Safe Kids/Office of the State Fire Marshall, the NC Dept of Transportation (DOT), the NC Child Fatality Task Force (CFTF), NC State Child Fatality Prevention Team (SCFPT), local Child Fatality Prevention Teams (CFPTs), and the Highway Safety Research Center (HSRC) to assure proper installation of child safety seats, to encourage backseat seatbelt use, to reduce impaired driving, and to promote All-Terrain Vehicle (ATV) safety. Specific efforts included:
1. The IVPB convened an overall road safety goal team as part of its State Advisory Council.
2. Through the SCFPT, linkages have been made between county-level groups to assure better knowledge of local partners in helping to assure safe installation of infant and child safety seats.
3. The CFTF made recommendations to the Governor and Legislature to reduce child death due to MVC in three areas: school zone speeding, impaired driving with a child in the car, and distracted driving (banning use of a cell-phone while driving). Legislation passed in May and will

go into effect in August 2011 that increases the fine for speeding in a school zone to be equal to the fine for speeding in a construction zone (from $25 to $250). This will help protect pedestrians and demonstrate that NC values students as much as construction workers. It also offers an opportunity for parents to model safe speed driving to their children. Legislation also passed that increased the penalty for driving impaired with a child under age 18 in the car. Parents who are impaired are also less likely to properly buckle their children into car seats.
4. The educational focus for this year for the local CFPTs was on car safety and to raise awareness about the dangers of unsafe driving. The local CFPTs in all 100 counties provided vehicle safety education to their communities with 29% of local teams providing the education themselves and 67% collaborating with other agencies, such as law enforcement, Guardian Ad litem, LHDs, local DSS, local school systems and others. Teams also provided educational programs and workshops on car seat safety, proper car seat installation, and teen driving education. The Onslow County CFPT educated teens about the dangers of impaired driving at a teen summit. The Catawba County CFPT also focused on distracted driving. The Catawba team held a contest (complete with Facebook Page) among the local high school teens for the best video on the subject to be chosen by their peers. The winning video was utilized throughout their county as a teaching tool for the community, local high schools and the driver's education classes in May 2011. Topics included distracted driving activities to avoid while in the car: cell phone usage, eating & drinking, talking to passengers, reading maps and changing the radio station, CD or Mp3 player. Another local team collaborated with their local law enforcement to provide information about the dangers of small children riding motorcycles without proper small child restraint seats. That county has seen an increase of citations. Several teams provided posters and flyers on motor vehicle safety at local health fairs. Several teams were able to distribute car seats to low income families via small community grants.

LHDs continued to provide preventive health services to children and adolescents and to address motor vehicle safety with parents and youth (i.e., use of car seats and booster seats, seat belt use, not driving while impaired) as part of the anticipatory guidance provided at well child visits and through local community efforts and partnerships.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued review of child deaths due to motor vehicle crashes on the state and local levels.				X
2. CFTF advocates for new legislation aimed at preventing child deaths from motor vehicle crashes.				X
3. Community car seat distribution programs.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Work continues with partners noted previously. The CFTF convened state experts on teen road safety to suggest policies to improve teen road safety. Recommendations will improve overall road safety (by promoting driver education and mitigating barriers to participating in the graduated driver license system) and benefits will extend to younger populations. Safe Kids shared Countdown2Drive, a program designed to help parents of pre-drivers prepare their children to become safe drivers. The CFTF participates on the Executive Committee on Highway Safety to assure that children's concerns remain a focus. IVPB and CFTF participated in 2 day symposium

with international experts in October 2011 to determine strategies to effectively reduce speeding in NC. Safe Kids continues to assure child safety seats are installed correctly.

Local CFPTs review child deaths in MVCs and educate local communities on ATV safety, car seat safety, teen driving and the influence of alcohol.

The IVPB applied for grants from CDC to reduce injuries and death of children in MVCs. One proposal targets rear seat belt use and Driving While Impaired (DWI). The other proposal focuses on enhancing the policy work of the State Advisory Council; conducting market research, data collection and reporting; strengthening partnerships with DOT; and focusing on DWI and child maltreatment.

c. Plan for the Coming Year

One key theme that emerged in the Teen Road Safety Research Workgroup convened by the CFTF was the need to better engage parents in modeling and other teaching of safe driving skills. Possible related activities for the upcoming year include explore encouraging a national research project (Checkpoints) to include NC as a study site for parent engagement strategies, preserve parent education components of driver education, and work with partners to provide web or other resources to parents of young and pre-drivers.

Since failure to wear a seatbelt in a primary reason that passengers and others die in MVC, the CFTF will work on activities to promote usage:
- Education of the public about the recent effective increase in the cost of speeding (due to the inclusion of court costs)
- Legislation to change riding unbuckled in the backseat to a primary offense to allow law enforcement (LE) to stop a vehicle. This should increase National Highway Traffic Safety Administration funding to the state to allow for more safety activities and well as provide LE with another tool to promote seat belts.
- Promotion of the use of speed cameras in school zones. This proposal calls for a pilot project to complement last year's fine increase. Research shows the perception of the certainty of being caught is a greater deterrent than the fine level. It should help protect students walking to school, promote better modeling of safe driving by parents taking their children to school, and shape early driving behavior of teens driving themselves to school.

To improve data and thus understanding of the problem, the IVPB will work with traffic safety partners at Governor's Highway Safety to improve data on injuries caused by MVC by exploring linkages between crash data and injury data collected through hospital discharges and emergency departments. IVPB aims to increase surveillance of DWI and marketing research to get a better understanding of the hard core repeat offenders to form the basis of an intervention that could work for that population.

LHDs will continue to use required Bright Futures tools (required since January 2012) to ask questions and provide anticipatory guidance that is evidence-based related to car safety and driving during well child visits for infants, children, adolescents and their families.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	15.5	16.5	17	17.5	17.5
Annual Indicator	16.2	16.8	17.3	17.1	17.6
Numerator	13692	14678	15436	15106	14941
Denominator	84574	87504	89168	88228	84780
Data Source		WIC data - NC Health Services Information System	WIC data - NC Health Services Information System	WIC data - NC Health Services Information System	WIC data - NC Health Services Information System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	17.5	18	18	18	18

Notes - 2011
Data are for FY10. FY11 data will be available in March 2013. Data are delayed due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

Notes - 2010
Data are for FY09. FY10 data will be available in March 2012. Data are delayed due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

Notes - 2009
Data are for FY08. FY09 data will be available in March 2011. Data are delayed due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

a. Last Year's Accomplishments
According to the 2011 CDC Breastfeeding Report Card, NC has not met any of the HP 2020 breastfeeding goals of 81.9% of mothers ever breastfeeding (NC=67.3%), 60.6% of mothers breastfeeding at 6 months (NC=37%), and 34.1% of mothers breastfeeding at 12 months (NC=19.6%). Additionally the state rate for "exclusive" breastfeeding at 6 months is 8.2%.

Activities undertaken by the Nutrition Services Branch (NSB) in FY11 to further increase breastfeeding duration rates included:
-establishing two Regional WIC Lactation Training Centers bringing the total to six;
-expanding the WIC Breastfeeding Peer Counselor Program to 70 agencies;
-funding $417,840 in breastfeeding promotion and support mini-grants to 57 local agencies;

-providing "Grow and Glow" training to local agency Breastfeeding Coordinators;
-providing a statewide breastfeeding leadership conference for WIC breastfeeding staff;
-working with the NC Child Fatality Task Force (NC CFTF) to promote workplace lactation policies to the league of municipalities; and
-collaborating with the NC CFTF to develop a plan for reimbursement of lactation services provided by an International Board Certified Lactation Consultants (IBCLC).

Continuing activities of the NSB in FY11 included:
-working with the NC Breastfeeding Coalition (NCBC) to continue to build statewide infrastructure for breastfeeding support;
-co-sponsoring the NC Lactation Educator Training Program (NCLETP) (126 completed);
-developing a competency-based online breastfeeding supplies competency training program;
-promoting World Breastfeeding Week;
-supporting data collection and analysis;
-supporting the Kids Eat Smart Move More (ESMM) child care initiative;
-providing breastfeeding supplies, professional resources, and client education materials to local WIC agencies;
-working with NC Healthy Start Foundation (NCHSF) to promote a social marketing campaign in Eastern NC;
-implementing the NC Maternity Center Breastfeeding-Friendly Designation (NCMCBFD) Program; and
-assisting the Office of State Personnel (OSP) with implementation of the lactation policy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expansion and enhancement of Breastfeeding Peer Counselor Programs.		X		
2. Promote and recognize World Breastfeeding Week annually.			X	
3. Offer the North Carolina Lactation Educator Training Program two times a year.				X
4. Distribute electric & manual breast pumps and accessory kits to local WIC agencies throughout the state.		X		
5. Enhance and support accurate breastfeeding data collection and analysis.				X
6. Establish & maintain a Regional WIC Lactation Training Center in each perinatal region.				X
7. Assure local agency public health staff receive training in breastfeeding support & lactation management.				X
8. Offer training and consultation targeted toward childcare industry on breastfeeding and pumped breastmilk.				X
9. Distribute & promote a NC Blueprint Status Report.				X
10. Maintain the NC Maternity Center Breastfeeding Friendly Designation.				X

b. Current Activities
New activities undertaken in FY12 include:
-developing a breastfeeding-friendly child care designation;
-implementing the revised National Loving Support curriculum for Peer Counselors;
-assisting the NCBC and Mid South Lactation Consultant Association (MSLCA) with seeking licensure for IBCLCs in NC;
-releasing an RFA for six Regional WIC Lactation Training Centers;
-participating in an Interstate Collaborative looking at hospital based practices that support breastfeeding;

-providing technical assistance to Washington and Georgia with implementation of the NCMCBFD model;
-producing and disseminating the Blueprint Status Report; and
-assisting the Physical Activity and Nutrition (PAN) Branch with a revision of the workplace primer.

Continuing activities include:
-working with the NCBC to build and maintain infrastructure for breastfeeding support;
-co-sponsoring NCLETP (twice);
-implementing a competency-based online breastfeeding supplies competency training program;
-promoting World Breastfeeding Week;
-supporting data collection and analysis;
-providing breastfeeding supplies, professional resources, and client education materials to local WIC agencies;
-collaborating with NC CFTF to improve workplace policies for breastfeeding mothers;
-collaborating with NC CFTF in implementing a benchmark policy for insurers to cover IBCLC services;
-maintaining the NCMCBFD program; and
-assisting the OSP with implementation of the lactation policy.

c. Plan for the Coming Year
New activities planned by the NSB for FY13 include:
-representing the NCBC at the US Breastfeeding Committee/CDC State Coalitions meeting;
-sharing the NCMCBFD program model with other states;
-revising the NC HSF breastfeeding promotion campaign;
-assisting with the development of a model to increase minority healthcare providers trained in lactation; and
-assisting the NCBC and partners with a K-12 breastfeeding curriculum.

Continuing activities of the NSB in FY13 to promote and support breastfeeding include:
-implementing a breastfeeding-friendly child care designation;
-assisting the NCBC and MSLCA with seeking licensure for IBCLCs in NC;
-awarding a Request For Applications for six Regional WIC Lactation Training Centers;
-participating in an Interstate Collaborative looking at hospital based practices that support breastfeeding;
-disseminating the revised PAN/NSB workplace primer;
-working with the NCBC to build and maintain infrastructure for breastfeeding support;
-co-sponsoring NCLETP (twice);
- implementing a competency-based online breastfeeding supplies competency training program;
-promoting World Breastfeeding Week;
-supporting data collection and analysis;
-providing breastfeeding supplies, professional resources, and client education materials to local WIC agencies; -collaborating with NC CFTF in implementing a benchmark policy for insurers to cover IBCLC services;
-maintaining and providing technical support for the NCMCBFD program; and
-assisting the OSP with implementation of the lactation policy.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	97	97	98	98	98
Annual Indicator	94.6	94.6	95.2	96.5	97.1
Numerator	123107	126258	125895	123535	119475
Denominator	130067	133450	132252	127981	123068
Data Source		WCSWeb Hearing Link	WCSWeb Hearing Link	WCSWeb Hearing Link	WCSWeb Hearing Link
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	98	98	98	98	98

Notes - 2011
Prior to 2005, “before hospital discharge” was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based on this concern, the operational definition of “before hospital discharge” was changed to include all babies screened for hearing loss within 30 days of birth.

Notes - 2010
Prior to 2005, “before hospital discharge” was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based on this concern, the operational definition of “before hospital discharge” was changed to include all babies screened for hearing loss within 30 days of birth.

Notes - 2009
Prior to 2005, “before hospital discharge” was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based on this concern, the operational definition of “before hospital discharge” was changed to include all babies screened for hearing loss within 30 days of birth.

a. Last Year's Accomplishments
All 87 hospitals/birthing facilities in NC continued to provide newborn hearing screening (NHS). Data from the state's web-based data tracking and surveillance system for newborn hearing screening, WCSWeb Hearing Link (WCSWeb), for 2010 indicated:
Live Births = 123,068
Total Screened = 122,446 (99.5% of live births)
Total Screened by 1 month of age = 119,475 (97.1% of live births)

Prior to 2005, "before hospital discharge" was operationally defined by WCHS as within 48 hours

of birth. However, this definition did not take into account out-of-hospital births, babies born by cesarean section and infants admitted to a Neonatal Intensive Care Unit (NICU) who have hospital stays of more than 48 hours. Based on this concern, the operational definition of "before hospital discharge" was changed to include all babies screened for hearing loss within 30 days of birth.

The number of hospitals providing outpatient rescreens increased by four to 81 and other hospitals started to develop similar protocols. All hospitals completed annual Program Plans for newborn hearing screening. Consultants continued providing support and education for NHS programs. Hospital Toolkits were developed and new materials were added quarterly.

WCSWeb was implemented in 8 more hospitals, bringing the total to 82 hospitals that used WCSWeb. Staff members from all hospitals on WCSWeb were trained to do direct data entry for demographic information and hearing screening results. WCSWeb was used to determine data for the most recent (CY10) Hearing Screening and Follow-Up Data Report for CDC, and was able to provide data on the number of babies screened and the percent that passed or referred on a hospital-by-hospital basis. A CDC Cooperative Agreement was continued to help support improvements in WCSWeb, as well as tracking and surveillance activities. Centralized data staff provided tracking and surveillance for all 100 counties.

Child Health Speech Consultants (SLCs) provided ongoing technical assistance, consultation, and support to hospitals and families. They continued working with families whose children needed to have an audiological diagnosis completed. The percentage of infants who were diagnosed by 3 months of age increased from 52.5% in 2009 to 55.7% in 2010.

Child Health Audiology Consultants (CHACs) provided consultation and technical assistance to primary care physicians. They continued to provide notebooks containing child-specific information, EHDI program information, general hearing loss information, and information about C&Y Genetic Counselor services to medical homes when a child in the practice was identified with hearing loss. CHACs made home visits to parents of children identified with hearing loss when requested. They also trained LHD nurses to use audiometry and otoacoustic emission equipment (OAE) for hearing screening and tympanometry for possible otitis media.

A single point of entry referral process was continued, expediting referrals to EI services. Parents signed releases at the time of diagnosis which allowed the EHDI program to share their information with service providers.

The EHDI Advisory Committee, which includes five parents, continued to meet quarterly. Subcommittees continued to address specific concerns. Consultants and Advisory Committee members presented EHDI program information at hospital grand rounds for medical students and residents.

State legislation requiring NC insurance companies to cover hearing aids for children birth to 21 years went into effect on 1/1/11. Members of the EHDI Advisory Committee and their children were active in helping with advocacy for this legislation.

C&Y Branch funding continued for initial hearing aids, earmolds and batteries for a year, free of charge to eligible children with hearing loss.

An MCHB grant for EHDI Follow-Up was continued. Access to audiological diagnostic services continued in several underserved counties using Teleaudiology. The grant also included development of materials to help birthing facilities and rescreening sites to increase the number of families who return for needed follow-up.

A Hearing Healthcare Map was developed by parents and started to be given to parents whose infants did not pass their hearing screening to guide them through the EHDI process.

Translations of a newborn hearing screening brochure for hospitals were completed and made available online when needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhancements to the Newborn Hearing Screening Data Tracking and Surveillance System.			X	
2. Provide support to the local newborn hearing screening programs in birthing/neonatal facilities.				X
3. Identification of educational needs for pediatric audiologists, midwives, and primary care providers.				X
4. Regional staff assuring that all infants have access to screen and rescreen.		X		
5. Infants tracked through the screening, evaluation, and amplification process to assure no children missed.			X	
6. Development and implementation of training opportunities for pediatric audiologist, midwives, and primary care providers.				X
7. Coordination of referrals and information sharing for intervention services.				X
8. Development and implementation of EHDI data quality assurance plan.				X
9. Development and distribution of educational materials to hospitals, families, and providers.			X	
10. Regional staff providing support to families of children needing a diagnostic hearing evaluation.		X		

b. Current Activities

The following activities continue: NHS programs at hospitals; consultants providing support and education; Program Plans; additions to Hospital Toolkits; and WCSWeb trainings.

CHACs educate primary care providers (PCPs) about EHDI and hearing loss when they deliver notebooks to those who have a child identified with hearing loss. They make home visits to parents when requested.

CDC awarded a new Cooperative Agreement to NC for continued enhancement and interoperability of WCSWeb, including an evaluation plan to assess the effectiveness of the EHDI program. Intervention data was added to WCSWeb. NC is a pilot state for a CDC project to develop a national list of pediatric audiology sites.

The Teleaudiology Project is expanding from four to seven sites within the established telemedicine network, including a new location with a significant Native American population.

Partnering for Progress was held in Raleigh during October and over 400 participants attended the three combined meetings that occurred.

Families remain active participants in EHDI program development. The Family Care Notebook was developed by parents, the EHDI staff, and the EI Branch to help parents organize the documentation of a child's hearing loss. Posters for PCP offices have been designed and will be piloted in about 40 pediatric clinics. The CARE Project continues to involve parents and professionals in a workshop for dealing with the emotions that come with a diagnosis of hearing loss.

c. Plan for the Coming Year
The following birthing center activities will continue: annual Program Plans; NHS education for nursery staff; and additions to hospital NHS toolkits including brochures, Hearing Healthcare Maps, and other parent education materials.

SLCs will continue to support families from failed rescreen to diagnosis; collaborate with prenatal educators, early childcare providers, and community agencies to incorporate information about NHS, hearing loss, and speech development in their curriculum; and provide EHDI informational packets to home visitors and midwives.

CHACs will continue the following activities: training for local health department staff on hearing screening and childhood hearing loss; physician education at the time of diagnosis; outreach to Head Start programs; and training for audiologists regarding EHDI reporting requirements.

EHDI staff will collaborate with Parents As Teachers to develop process for completing annual physiological hearing screenings. The EHDI program will continue to collaborate with CC4C Care Managers, CCNC, and Home Visiting programs to provide services to families after a child has been diagnosed with hearing loss.

WCSWeb will be linked to Vital Records birth and death files. Collaboration with the NC State Laboratory of Public Health regarding quality of NBS and NHS data will continue. EHDI staff will continue to train intervention providers, additional health care providers, and public school personnel in the use of WCSWeb. Home visitors will be provided WCSWeb access as needed.

The EHDI Advisory Committee will continue to meet quarterly. The committee will continue to work with the NC Pediatric Society to select an American Academy of Pediatrics (AAP) EHDI Chapter Champion. Consultants and Advisory Committee members will continue to present information at hospital grand rounds and to medical students and residents.

Parents will continue to work with EHDI staff in the development and review of new materials. Additional materials will be translated into Spanish and other languages as needed. A directory of Spanish speaking parents who have been trained and are willing to offer support to families of newly identified hearing impaired children will be developed and distributed. EHDI staff, parents, and the CARE Project are partnering to provide workshops throughout the state to increase and enhance family support. A Family Care Notebook to organize documentation related to a child's hearing loss has been developed and will be distributed by EI teachers.

Evaluation of the effectiveness of the EHDI program will continue. Quality improvement methodology learned through participation in the National Initiative for Children's Healthcare Quality (NICHQ) Project and collaboration with the NC Center for Public Health Quality will continue to be implemented.

In order to meet needs in rural areas, the Teleaudiology Project will continue in eastern NC. The project will be expanded to include an eighth site.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10	10	10	10	10

Annual Indicator	13.1	13.3	11.3	11.0	10.9
Numerator	302690	310673	271600	269000	266105
Denominator	2314354	2340346	2407700	2440400	2446663
Data Source		Urban Institute & Kaiser Comm Medicaid & Uninsured	Urban Institute & Kaiser Comm Medicaid & Uninsured	Urban Institute & Kaiser Comm Medicaid & Uninsured	Urban Institute & Kaiser Comm Medicaid & Uninsured
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	10	10	10	10	10

Notes - 2010
FY10 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2009 and 2010 Current Population Surveys for children <18. (CPS: Annual Social and Economic Supplements). Accessed at following url: http://www.statehealthfacts.org.

Notes - 2009
FY09 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2008 and 2009 Current Population Surveys for children <18. (CPS: Annual Social and Economic Supplements). Accessed at following url: http://www.statehealthfacts.org.

a. Last Year's Accomplishments
On 06/26/2011, 142,048, children were enrolled in NC Health Choice (NCHC); 864,175,442 in Health Check (HC), Medicaid for children. 2010 ACS estimates report 7.74% of children <=18 years old are uninsured. NCHC faced a 6% enrollment growth cap which was reached when enrollment growth was 6.03% on 6/26/2011.

C&Y Branch Staff focused on three priority areas.
1. Health Check enrollment targeted:
-Children <6 years through NC CHIPRA Grant (NCPS). Targeted children entering kindergarten by working with child care, Head Start, More-at-Four/Pre-K Programs, and others.
-Unemployed/under-employed parents through partnerships with the Division of Employment Security (DES); Connect Inc.; and other means-tested programs including homeless families, families in foreclosure, low income housing applicants through the US Department of Housing and Urban Development (HUD), NC Housing Coalition, homeless shelters, urban ministries, food banks.

-CSHCN and minority populations: Strategic plan to promote access to care for CSHCN. NC's waiver of 5-year waiting period for legal immigrant children and pregnant women approved for Medicaid. Minority outreach through consulate events, cultural festivals, minority-owned businesses and faith-based and community-based organizations. The HC/NCHC Fact Sheet continued to be available in 12 languages.
-Families served by safety net providers were encouraged to apply.
-School Lunch Program, through express lane enrollment (a file match with TANF), continued to promote HC/NCHC in approval letters.
2. Simplification strategies related to enrollment/retention were developed.
3. Implementation of an electronic database to screen families for multiple means-tested programs utilizing the Benefits Bank, a private proprietary product, were initiated but because lack of funding did not move forward.

The CSHCN Help Line continued to work with families and providers to assist with sharing information about eligibility for HC and NCHC and the application process.

LHDs continued to provide or assure preventive health, primary care services, medication assistance and other services to children without health insurance using some of their funding from the C&Y Branch.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain HC/NCHC Outreach Campaign in partnership with the NC Healthy Start Foundation.			X	
2. Simplification of enrollment/re-enrollment forms and continued development of family-friendly notices.		X		
3. Development of comparable data sets for HC and NCHC.				X
4. Targeted outreach to special populations (including minority and CSHCN).			X	
5. Development of infrastructure to promote and sustain HC/NCHC outreach.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Enrollment in NCHC and HC is growing. HC enrollment is targeting children <6 years of age. C&Y Branch staff are collaborating with NCPS's Healthy and Ready to Learn (HRTL) grant from the ORH to target 950 elementary schools in 46 counties. Work with child care, Head Start, Pre-K programs, and others continues. One position supporting outreach was lost but the Latina outreach staff member continues to target needy populations by promoting NCHC and HC through partnerships with safety-net providers and other means-tested programs listed above.

DMA has implemented automatic re-enrollment to decrease burden on families by matching records. Efforts will continue to focus on re-enrollment to ensure continuity of care in the event that the NCHC program reaches its maximum enrollment capacity. The NC Coalition to Promote Health Insurance for Children meets at least three times per year to discuss collaborative efforts. The policy team at DMA has initiated an Advocates quarterly meeting to address budgetary constraints and implementation of ACA.

A teleconference was held in Pitt County with parents whose insurance did not cover hearing

aids.

The NC Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program conducted planning with Healthy Families America and Nurse-Family Partnership sites and state-level stakeholders to support home visitors in accessing health insurance for children.

c. Plan for the Coming Year
Enrollment in NCHC and HC is anticipated to grow in the coming year as the economy is rebounding slowly. HC enrollment will continue to target children <6 years through collaboration with NCPS's Healthy & Ready to Learn grant. Work with child care, Head Start, Pre-K programs, and others will continue.

Efforts will continue to focus on re-enrollment in NCHC to ensure continuity of care in the event that the program reaches its maximum enrollment capacity. The NC Coalition to Promote Health Insurance for Children will continue to meet at least three times per year to discuss collaborative efforts to reach targeted populations and share new resources for local communities. The policy team at DMA has initiated an Advocates quarterly meeting and will address the changes required to meet budgetary constraints and in preparation for implementation of ACA.

The Latina minority outreach staff member will continue to target the following populations including:
-unemployed/under-employed through partnerships with the DES and other means-tested programs;
-Free & Reduced lunch programs, through express lane enrollment (a file match with Temporary Assistance for Needy Families [TANF]), which continues to promote HC/NCHC in approval letters and training webinars;
-homeless people, families in foreclosure, and low income housing applicants through HUD, NC Housing Coalition, homeless shelters, urban ministries, and food banks;
-CSHCN and minority populations by updating a fact sheet which is available in 12 languages; and
-families served by safety net providers at community health centers and free clinics.

In partnership with the NC Healthy Start Foundation, podcasts will be created instead of fact sheets in at least four additional languages.

As a lead state in an Action Learning Collaborative grant from AMCHP and the National Center for Ease of Use of Community-Based Services, the C&Y Branch's bilingual-bicultural Latina outreach worker will lead webinars and site visits to identify successful projects serving Latino families with CSHCN.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	25	25	25	25	25
Annual Indicator	30.4	31.0	31.6	31.8	31.6
Numerator	27491	24719	28453	33500	32824
Denominator	90390	79667	89904	105410	103874
Data Source		NC-NPASS	NC-NPASS	WIC	WIC

		(Nut & PA Surveillance System)	(Nut & PA Surveillance System)	Surveillance System	Surveillance System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	25	25	25	25	25

Notes - 2011
Data for CY2010 and CY2011 are different from previous years as they only include WIC participants, not all children in the NC-NPASS. The reason for this change was to get a larger selection of children. WIC records have valid height and weight information on all records as opposed to child health records. As a consequence of the previous methodology for record selection if a child health visit preceded WIC visit there was a greater likelihood of not picking that record because of an invalid height and weight data. So, CY10 data and beyond are not comparable to CY09 data and previous years.

Notes - 2010
Data for CY2010 and CY2011 are different from previous years as they only include WIC participants, not all children in the NC-NPASS. The reason for this change was to get a larger selection of children. WIC records have valid height and weight information on all records as opposed to child health records. As a consequence of the previous methodology for record selection if a child health visit preceded WIC visit there was a greater likelihood of not picking that record because of an invalid height and weight data. So, CY10 data and beyond are not comparable to CY09 data and previous years.

Notes - 2009
Data Source: NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) The subselection of WIC has been done from the composite NC-NPASS file. The annual composite file is created by combining the records from the WIC, Child Health and CSHS. The first records are kept during unduplication. So if a child visits the Child Health clinic first followed by WIC on a different day, the child health record would be kept provided the heights and weights are available. So depending on how a visit occurs, the numbers could vary from year to year and as such the numbers are very much dependent on which records gets selected.

a. Last Year's Accomplishments
The percentage of children ages 2 to 5 years receiving WIC services with a Body Mass Index at or above the 85th percentile remained at almost 32% in CY11. Efforts undertaken by the NSB in FY11 to help reduce this percentage included the following activities:
-offered training to local health agency staff on nutrition assessment and care plans;
-offered training to local health agency staff on breastfeeding promotion and support;
-offered training to local public health nutritionists on motivational interviewing;

-offered training to local health agency staff on methods of promoting behavior change;
-offered the Pediatric Nutrition Course to local agency staff and private providers
-promoted and supported breastfeeding;
-used NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) data to monitor pediatric overweight;
-identified resources for local WIC staff to use to promote healthy weight in children; and
-implemented a USDA Child Care Wellness Grant which included obesity prevention efforts, development of meal and snack guidelines for meals in child care centers, provision of mini-grants to child care providers, menu planning training, and on-line training modules for child care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhancement of Nutrition and Physical Activity Surveillance System (NC-NPASS).				X
2. Education of health care professionals/staff training.				X
3. Education of children and their parents/caretakers.		X		
4. Implement WIC program policies supportive of dietary change.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In FY12, the NSB is performing these new activities in an effort to reduce childhood overweight and obesity:
-offering training to local health agency staff on nutrition risk codes;
-offering training to local health agency staff on World Health Organization's (WHO) Growth Charts;

In addition, the NSB continues to perform these activities:
-offering training to local health agency staff on breastfeeding promotion and support;
-offering training to local public health nutritionists on motivational interviewing;
-offering the Pediatric Nutrition Course to local agency staff and private providers;
-implementing a USDA Child Care Wellness Grant which included obesity prevention efforts, development of meal and snack guidelines for meals in child care centers, provision of mini-grants to child care providers, menu planning training, and on-line training modules for child care providers;
-promoting and supporting breastfeeding;
-using NC-NPASS data to monitor pediatric overweight; and
-identifying resources for local WIC staff to use to promote healthy weight in children.

c. Plan for the Coming Year
The NSB plans to conduct the following activities in FY13:
-offer training to local health agency staff on breastfeeding promotion and support;
-offer training to local public health nutritionists on motivational interviewing;
-offer the Pediatric Nutrition Course to local agency staff and private providers;
-offer training to local health agency staff on the 2010 Dietary Guidelines and MyPlate;

-promote and supporting breastfeeding;
-use NC-NPASS data to monitor pediatric overweight;
-explore social marketing options targeting "Healthy Habits, Healthy Families" Behaviors;
-identify resources for local WIC staff to use to promote healthy weight in children; and
-continue implementation of a USDA Child Care Wellness Grant which included obesity prevention efforts, development of meal and snack guidelines for meals in child care centers, provision of mini-grants to child care providers, menu planning training, and on-line training modules for child care providers.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	12	11	10	10	10
Annual Indicator	11.5	11.0	10.4	10.2	10.2
Numerator	14668	14426	13621	12975	12975
Denominator	127646	130886	130758	126785	126785
Data Source		NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	10	9	9	9	9

Notes - 2011
North Carolina adopted the 2003 revision of the U.S. Standard Certificate of Live Birth beginning in August 2010. Birth data were collected according to the 1989 U.S. standards from January through July of 2010. Data items related to educational attainment, prenatal care initiation, and tobacco use were collected differently on the 1989 and 2003 revised certificates and are not comparable. As a result, 2010 data for this NPM are not available. CY09 has been repeated as data must be entered into the system. The CY09 data are for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data obtained through vital records from the NC State Center for Health Statistics. The annual performance objectives are also based on women who smoked during pregnancy, not just in the

last three months. For CY11, data on the number of women who smoked just in the last three months should be available.

Notes - 2010
Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here are CY09 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data obtained through vital records from the NC State Center for Health Statistics. The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

Notes - 2009
Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here are CY08 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data obtained through vital records from the NC State Center for Health Statistics. The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

a. Last Year's Accomplishments
Since FY06 and continuing through FY13, the Local Health Department Maternal Health Agreement Addendum has mandated that all local health departments comply with the following criteria which are monitored via the maternal health audit tools:

"The Health Department shall provide the 5A method for tobacco cessation to all pregnant and postpartum women using the 5As (ask, advise, assess, assist, arrange) as recommended by ACOG and referral made to appropriate community resource or the NC Tobacco Use Quit Line at 1-800-QUIT-NOW. Another resource is the "Guide for Counseling Women who Smoke, March 2008"." (Guidelines for Perinatal Care, p. 94-96)

The Maternal Health Psychosocial Screening Forms have also been updated to assess for tobacco use during pregnancy, not only on the initial intake, but during every pregnancy trimester and postpartum. The direct questions are as follows:

Initial Questions: Do you smoke or chew tobacco or dip snuff? Do others smoke around you?
Trimester and Postpartum Question: Since the last time we asked you, have you started smoking, chewing tobacco or dipping snuff?

Smoking assessment is also included on the new Pregnancy Medical Home risk screening form.

LHD staff members are currently being trained to improve competence in both smoking cessation counseling and Medicaid coding and billing for smoking cessation counseling.

North Carolina's three Healthy Start Projects - Eastern, Northeastern and Triad Baby Love Plus - conducted community wide outreach in which smoking cessation information was shared to pregnant women and women of childbearing age 15-44 at venues such as house parties (i.e., Tupperware, Mary Kay), baby showers, health fairs, and other community events. Twenty-two (22) Community Health Advocates (CHAs) participated in 4,006 events, reaching 64,208 women of childbearing age covering 14 NC counties. During the interconceptional period, Family Care Coordinators screen all newly enrolled participants for prenatal tobacco use at the initial assessment. Referrals to tobacco cessation programs and ongoing follow up contacts are made for women who express a desire to quit.

In FY11, the WHB also conducted statewide Preconception Peer Education training reaching ten universities. Five of the participating universities have established certified Preconception Peer Education programs on campus. The students provided campus and community outreach

around perinatal health issues. The training included information on impact of tobacco use and exposure on perinatal health outcomes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update and distributetobacco cessation educational materials.			X	
2. Facilitate and manage the Women and Tobacco Coalition for Health activities.				X
3. Develop/sustain partnerships with women's health and tobacco use prevention/cessation organizations.				X
4. Continue to train and support Preconception Peer Educators on NC university campuses.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Ongoing assessment activities in local health departments and Pregnancy Medical Home mentioned above continue.

North Carolina's three Healthy Start Baby Love Plus (BLP) projects continue to carry out outreach and client recruitment activities in which tobacco cessation information is shared with pregnant women of childbearing age. Between July 1, 2011 and May 1, 2012, twenty-one CHAs participated in 3,115 events, reaching 47,074 women of childbearing in 14 NC counties. During the interconceptional period, Family Care Coordinators continue to screen all newly enrolled participants for prenatal tobacco use at the initial assessment and make appropriate referrals.

The Women's Health Branch (WHB) conducted statewide Preconception Peer Education (PPE) training to five universities in November 2011 and provides continuing support to the established PPE Programs including supplemental training (April 2012) and support to campus and community outreach. Campus-to-Community Partnership training was provided for one select university PPE Program in May 2012.

Women and Tobacco Coalition for Health (WATCH) meetings continued with four quarterly meetings held during the fiscal year. WATCH provided input into the development of the You Quit, Two Quit (YQTQ) postpartum recidivism program and the creation of educational materials including the YQTQ booklet.

c. Plan for the Coming Year

BLP Enhanced and Family Care Coordinators will be trained in the 5As evidence-based curriculum.

The WHB will continue the Preconception Peer Education program on NC university campuses. A statewide training will be held in September 2012 reaching additional universities. The WHB will continue to provide support to those universities with established programs (on-going), including assisting with on-campus training and providing continuation update training in the spring of 2013. Also during FY13, the WHB will provide technical support to Johnson C. Smith University in establishing an infant mortality prevention task force in Charlotte, NC.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	6	6	6	6	6
Annual Indicator	6.8	6.1	6.5	9.4	7.0
Numerator	42	39	44	62	46
Denominator	621709	638873	678263	658030	661614
Data Source		NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	6	6	5.5	5.5	5.5

Notes - 2011
Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

FY year data are actually the prior calendar year, e.g. FY11 is really CY10.

Notes - 2009

Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

FY year data are actually the prior calendar year, e.g. FY09 is really CY08.

a. Last Year's Accomplishments

From 2006 to 2008, the average number of suicides was about 42 youth suicides per year. After an unusually high number of teen suicides in 2009 (62), the number returned closer to its recent average for 2010. There were 46 suicides among youth ages 15 to 19 for a rate of 7 suicides per 100,000 youth.

IVPB Suicide Advisory Committee (SAC) convened key stakeholders to address strategies to reduce suicide. A youth suicide prevention grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) provided program funds to support the Gate Keeper training component of the state youth suicide prevention plan "Saving Tomorrows Today". Planning work was established to provide four different Gate Keeper training models of Applied Suicide Intervention Skills Training (ASIST) training through the 57 School Based-School Linked Health Centers and 100 school Child and Family Support Teams in the state. A total of 87 ASIST workshops included five regional workshops for the N.C. Community College System Adult Basic Education program, two workshops for public schools, and two for major universities. Over 200 participants were trained.

A Training of Trainers in the Lifelines curriculum was held for individuals who could train health educators and physical education teachers. The Lifelines curriculum is a school-based suicide prevention program that can be used within the North Carolina standard Healthy Living curriculum. Eight trainers from the NC Comprehensive School Health Training Center (NCCSHTC) and a Suicide Prevention Program Manager from the military base at Fort Bragg became trainers, and 109 school health educators and physical education teachers were trained.

Ground work was also done to develop a youth suicide prevention web site, including conducting youth focus groups at schools across the state to develop key messages and web site design characteristics. Youth and adult suicide prevention materials such as the following were created: wallet cards, brochures, banners, pocket folders, t-shirts, pencils, and wrist bands.

The NC Legislature eliminated funding for the CARELINE which served as the youth suicide hotline. These functions were quickly transferred over to NC Suicide Prevention Hotline which is staffed 24/7.

Given the rise in prescription drug abuse and the link between such abuse and depression and other mental health issues, the CFTF joined with Safe Kids, the State Bureau of Investigation, the Drug Enforcement Association, and others to promote prescription drug drop-off events. Permanent drop-off sites are being explored and poised to expand once federal guidance is clear.

IVPB has worked closely with Project Lazarus, a recognized and awarding program for reducing prescription drug abuse.

School nurses continued to offer referrals and individual health counseling for students who express feelings of depression, suicidal ideation, and/or report attempted suicides of other students.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. C&Y Branch staff members serve on the North Carolina Youth Suicide Prevention Task Force (YSPTF) and participate in its activities.				X
2. The CFTF advocates at the legislative level for recommendations made by the YSPTF.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Youth Suicide Prevention Program launched www.Itsok2ask.com, a website targeting NC youth. SAMHSA featured the site on its suicide prevention resource center. Two media campaigns led to in-depth coverage and 5,000 daily website hits.

1,000+ "gatekeepers" who work with children were trained in ASIST model, resulting in more than 100 youth referrals for suicide intervention by Mental Health professionals. Early evaluation by the UNC Injury Prevention Research Center shows statistically significant increases in awareness and intervention at 3 and 12 months. This training targets counties with the highest military population.

The "Ally" program was launched to train teachers to support Lesbian, Gay, Bisexual, Transgender, & Questioning (LGBTQ) youth. A film featuring NC LGBTQ youth discussing suicide issues has been produced.

CFTF committee's work on youth suicide prevention, post-intervention and depression treatment has led to recommendations to protect key programs to treat trauma and depression.

The Garrett Lee Smith grant ended, but the IVPB was refunded through July 2014 to focus on suicide prevention activities for military families, LBGTQ, and youth in the juvenile justice system.

C&Y Branch staff participated in a task force to design and implement a web-based module for middle and high school staff to recognize and address mental health issues and suicidal ideation. The first module was featured at the fall Carolinas Conference on School Mental Health.

c. Plan for the Coming Year
ASIST training during the year will target families of National Guard troops, youth in the juvenile justice system, and additional counties with high military population. More Lifelines Postvention curriculum trainers will be trained who will offer more training to public school staff on how schools and communities can respond.

The Youth Suicide Prevention team will explore ways to reduce suicidal thoughts and behavior in younger children. This is based on data that revealed that 10% of ASIST referrals through October 2011 were children under age 9.

The NC LAUNCH program will continue to work to strengthen recognition and treatment of depression and other mental health conditions in young children.

The IVPB will continue working with the NCIOM and other partners to develop a specific youth suicide reduction plan for the state. The IVPB State Advisory Council will continue to seek goal

team input for strategies to reduce suicide for people of all ages.

Local CFPTs will continue their efforts to educate teens and parents on identifying the signs and symptoms of depression and suicide in an attempt to decrease child deaths due to suicide. One local team (Wake) is interested in working to strengthen safe storage laws.

School nurses will continue providing individual health counseling and referrals for students who come to them with feelings of depression, suicidal ideation, and suicidal reports of others.

C&Y Branch staff will continue to work with the DPI and other agencies on the NC Youth Suicide Prevention Task Force to promote use of the first mental health module by school staff to address mental health issues for middle and high school students and to develop a second web based module that will focus on helping school staff to be able to recognize and address mental health issues and suicidal ideation in students in pre-school through grade six

The Intentional Death Prevention Committee (IDPC) of the CFTF will explore ways to: 1) institutionalize funding and support for the NC Child Treatment Program to assure access to evidence-based mental health treatment for children and youth across NC by emphasizing clinical quality, treatment fidelity, achievement of targeted clinical outcomes, and costs savings to communities and to the state; 2) support increased screening and stronger linkages to appropriate medical/mental health treatment for children and youth with mental illness and trauma symptoms, including teens at-risk for suicide; 3) promote greater use of Evidence Based Programs (EBP) implemented with fidelity (including rostering of providers, coaching, data collection/program evaluation, and preparation time) to build resiliency and prevent death, violence and other negative outcomes; 4) maximize use of existing infrastructure to support EBP with fidelity; and 5) monitor treatment of children with psychotropic prescriptions.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	83	83	83	83	83
Annual Indicator	78.2	78.3	78.4	79.8	75.9
Numerator	1559	1595	1512	1550	1367
Denominator	1993	2036	1928	1943	1801
Data Source		NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	83	83	83	83	83

Notes - 2011
The data source is NC vital records as reported in the 2010 North Carolina Infant Mortality Report, Table 10, Risk Factors and Characteristics for North Carolina Resident Live Births found on the NC State Center for Health Statistics website.

Notes - 2010
The data source is NC vital records as reported in the 2009 North Carolina Infant Mortality Report, Table 10, Risk Factors and Characteristics for North Carolina Resident Live Births found on the NC State Center for Health Statistics website.

Notes - 2009
The data source is NC vital records as reported in the 2008 North Carolina Infant Mortality Report, Table 10, Risk Factors and Characteristics for North Carolina Resident Live Births found on the NC State Center for Health Statistics website.

a. Last Year's Accomplishments
The High Risk Maternity Clinic Program (HRMC) provided risk-appropriate care for more than 2600 women in North Carolina in 2011 at 11 High Risk Maternity Clinics. These women, with medically high-risk pregnancies, are assessed for medical, nutritional and psychosocial needs and a care plan developed to help them through the pregnancy. Prepregnancy BMIs are collected and special attention is paid to the mother's nutritional situation in order to reduce low-weight births. Delivery plans include matching them to a tertiary care center for the potential high risk needs of their infant.

All of the clinics were offered or provided training for the Licensed Clinical Social Worker (LCSW) in identifying and treating perinatal depression. Additional training was offered and provided regarding health and behavior intervention so that any woman with high risk psychosocial issues can be seen by a LCSW in the High Risk Clinic. Technical assistance is provided for all clinics regarding psychosocial issues by a Clinical State Social Work Consultant. Regular trainings are offered throughout the year and a listserve is maintained to keep the LCSW informed of trends and information regarding high risk psychosocial issues, particularly depression.

BLP Enhanced and Family Care Coordinators provide case management services to postpartum women who have delivered a low birth weight infant.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue the High Risk Maternity Clinic Program.	X			
2. Continual review of data to assess sites more likely to keep low birthweight babies.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The HRMC Program funded 11 clinics within local health departments. With the transition to the Pregnancy Care Management system of care (see NPM #18 for a description of this system), services to high risk women across the state have been improved with the use of a high risk screening tool which includes histories of low birth weight infants and preterm labor. HRMC providers continue to receive training on the Pregnancy Medical Home program which involves partnerships between the health department and private providers.

NC has made tremendous inroads in moving forward the incorporation of 17 alpha hydroxyprogesterone caproate (17P) into clinical practice. The investment in the NC 17P project on the part of the NC General Assembly and DPH represents a strong desire to use the tools available to eliminate health disparities and reduce preterm birth. This initiative highlights NC's interest in embracing clinical best practice and connecting public health leaders and clinicians in a targeted endeavor to serve a specific population of women at risk for preterm birth.

Baby Love Plus Enhanced/Family Care Coordinators and Community Health Advocates received training on chronic conditions experienced by pregnant women that could adversely impact birth outcomes. Information on the Life Course Perspective was shared and CityMatCH's Life Course Game was introduced to local BLP staff during a two-day skill building training held January 2012.

c. Plan for the Coming Year
In FY13, the HRMC Program will continue to fund local health departments in the provision of high risk services. It is projected that 3,000 women will be served. Funds to reinstate the East Carolina University High Risk Maternity Clinic were appropriated for FY13.

The WHB will continue to support Pregnancy Medical Home efforts, inclusive of Pregnancy Care Management, to ensure outcome measures are achieved.

Baby Love Plus staff will receive follow up training and information on the Life Course Perspective.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	87	87	87	87	87
Annual Indicator	81.9	80.9	82.0	83.3	83.3
Numerator	104528	105849	107183	105626	105626
Denominator	127646	130886	130758	126785	126785
Data Source		NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates	NC Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	87	87	87	87	87

Notes - 2011
North Carolina adopted the 2003 revision of the U.S. Standard Certificate of Live Birth beginning in August 2010. Birth data was collected according to the 1989 U.S. standards from January through July of 2010. Data items related to educational attainment, prenatal care initiation, and tobacco use were collected differently on the 1989 and 2003 revised certificates and are not comparable. As a result, 2010 data for this NPM are not available. CY09 has been repeated as data must be entered into the system.

Notes - 2010
The data source is NC vital records as reported in the 2009 North Carolina Infant Mortality Report, Table 10, Risk Factors and Characteristics for North Carolina Resident Live Births found on the NC State Center for Health Statistics website.

Notes - 2009
The data source is NC vital records as reported in the 2008 North Carolina Infant Mortality Report, Table 10, Risk Factors and Characteristics for North Carolina Resident Live Births found on the NC State Center for Health Statistics website.

a. Last Year's Accomplishments
The Baby Love Maternity Care Coordinators have provided prenatal case management services to low-income statewide, as early in pregnancy as possible, since the program began in 1987. On March 1, 2011, Maternity Care Coordination services were reconceived and a new model of prenatal care coordination called Pregnancy Care Management (PCM), which was implemented in local health departments statewide. Pregnancy care managers continue to link low-income pregnant women to prenatal care services as early in pregnancy as possible.

North Carolina's three Healthy Start BLP projects conducted community wide outreach at various venues to identify, recruit, and refer pregnant women into local systems of care. Strategies to reach pregnant women include house parties, baby showers, door to door, health fairs, and other community events. The CHAs also assist pregnancy care managers in reaching pregnant women who miss appointments and/or are lost to follow up and re-connect them to prenatal care services.

The WHB conducted Preconception Peer Education training reaching 10 NC universities and training 48 students. Five universities have established certified Preconception Peer Education programs on campus. The students provided campus and community outreach around perinatal health issues.

Healthy Beginnings, NC's Minority Infant Mortality Reduction Program, provides the opportunity for community agencies to impact families of color to improve minority birth outcomes through outreach, education and support. Funded agencies work closely with pregnant and newly parenting mothers for up to two years postpartum. Healthy Beginnings participants are able to set and work toward goals for themselves that will positively affect their families (i.e. healthy weight,

reproductive life planning). Wrap-around services are offered (education, transportation, group counseling, housing, etc.) to support mothers and young families as they begin and continue their journeys into parenthood. The focus includes case management using paraprofessionals and education on subjects such as healthy weight, folic acid consumption, safe sleep, tobacco cessation, breastfeeding promotion, and reproductive life planning. Fatherhood involvement is included at most sites. In the 2010 - 2013 award cycle for Healthy Beginnings, there were 26 applications, and 12 sites were awarded implementation funding. During CY2010, 900 babies were born to mothers in these projects and no infant deaths were reported.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pregnancy Care Management services are ongoing.		X		
2. Healthy Beginning Projects continue.				X
3. Continued outreach through Baby Love Plus with a focus on perinatal women's health.		X		
4. Work with Sickle Cell Program to educate families of childbearing age on perinatal health issues.				X
5. Preconception Peer Education program at NC universities will continue.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

PCM services are available to eligible low-income women in all 100 North Carolina counties. Eligibility is targeted to women with priority risk factors which place them at a higher risk for a poor birth outcome. Care managers also work in close collaboration with prenatal care providers, ensuring that women have access to prenatal care as early in pregnancy as possible. The primary mechanism for identifying Medicaid-eligible women with priority risk factors is the completion of a risk screening form by a Pregnancy Medical Home prenatal provider, who receives an incentive payment for this activity, which may also have a positive impact on early entry to prenatal care.

Community Health Advocates, Lay Health Advisors, Small Group Leaders (former Baby Love Plus program participants who receive facilitator training) and Ministry of Health Lay Leaders were trained as Community Health Coaches using the Ready, Set, Plan! curriculum (a preconception and interconception health resource kit). In addition, effective October 2011, the Eastern and Triad BLP Enhanced/Family Care Coordinators provide services to pregnant women with PCM non-priority risk factors.

c. Plan for the Coming Year

DPH, along with partner agencies CCNC and DMA, and local pregnancy care managers will continue to work closely with prenatal care providers and Pregnancy Medical Homes to encourage early access to prenatal care and address barriers, both at the community level and statewide. The patient identification process for PCM provides new information and data sources on the characteristics of pregnant women who are entering care after their first trimester and/or not receiving prenatal care.

NC Baby Love Plus CHAs plan to continue client outreach activities and aid in follow up and re-

engagement of pregnant women who become disconnected from the perinatal system of care.

The WHB will continue to expand the Preconception Peer Education program on NC university campuses and will provide support to those universities with established programs.

Funding for Healthy Beginnings projects will continue.

D. State Performance Measures

State Performance Measure 1: *Number of children affected in substantiated reports of abuse and/or neglect as compared with previous years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	24000	14000	12000	11500	11000
Annual Indicator	14744	12312	11171	11299	11562
Numerator					
Denominator					
Data Source		NC DSS CPS Central Registr	NC DSS CPS Central Registr	NC DSS CPS Central Registr	NC DSS CPS Central Registr
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11000	11000	10500	10500	10500

Notes - 2011
Data retreived June 26, 2012 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: http://ssw.unc.edu/ma/

North Carolina has implemented the Multiple Response System (MRS) statewide. MRS is an effort to reform the entire continuum of child welfare in North Carolina- from intake through placement services. The goal of MRS is to bring services and supports more quickly to families in need, called “frontloading”. Greater frontloading of services reduces the probability that a child would come back into the system within 6 months following an initial assessment finding services needed or a substantiation of abuse or neglect. In 2007 the recurrence of maltreatment did begin to decline by 27% (5.5% in SFY 2006-2007 as compared to 7.5% in 2001-2002).

Notes - 2010
Data retreived March 4, 2011 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: http://ssw.unc.edu/ma/

North Carolina has implemented the Multiple Response System (MRS) statewide. MRS is an effort to reform the entire continuum of child welfare in North Carolina- from intake through placement services. The goal of MRS is to bring services and supports more quickly to families in need, called “frontloading”. Greater frontloading of services reduces the probability that a child would come back into the system within 6 months following an initial assessment finding services needed or a substantiation of abuse or neglect. In 2007 the recurrence of maltreatment did begin to decline by 27% (5.5% in SFY 2006-2007 as compared to 7.5% in 2001-2002).

MRS has changed many data definitions and therefore trend data on assessments and substantiations are not available. MRS allows a two pronged approach to CPS involvement: The Family Assessment Track and the Investigative Track. While the Investigative track is the "traditional approach", which would lead to the unsubstantiation or substantiation of a case, the Family Assessment track does not. With the Family Assessment Track, families are found "in need of services", "services recommended", or "no services recommended". In February 2006, the NC Division of Social Services added a new finding for Family Assessments, "Services Provided, No longer Needed." This finding indicates that the safety of a child and future risk of harm are no longer issues because the agency has been successful in frontloading necessary services during the family assessment and therefore the case was neither substantiated or "Services Needed". As the Family Assessment Track of MRS can address neglect and dependency, some of the "Services Needed" reflects dependency allegations. (NC Division of Social Services, 2007).

Notes - 2009
Data retreived March 17, 2009 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: http://ssw.unc.edu/ma/

North Carolina has implemented the Multiple Response System (MRS) statewide. MRS is an effort to reform the entire continuum of child welfare in North Carolina- from intake through placement services. The goal of MRS is to bring services and supports more quickly to families in need, called "frontloading". Greater frontloading of services reduces the probability that a child would come back into the system within 6 months following an initial assessment finding services needed or a substantiation of abuse or neglect. In 2007 the recurrence of maltreatment did begin to decline by 27% (5.5% in SFY 2006-2007 as compared to 7.5% in 2001-2002).

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a. Last Year's Accomplishments
DPH remains the state level public agency lead for child maltreatment prevention in NC. The executive director (ED) of the Child Maltreatment Prevention Leadership Team (CMPLT) serves on the Fatherhood Advisory Council and continues work with the NC Parenting Education Network as well as the Alliance for Evidence-Based Family Strengthening Programs (The Alliance). Through The Alliance, DPH continues to build support to communities for implementation of EBPs with model fidelity. DPH continued efforts between state government sections and offices which resulted in several outcomes. First was a joint presentation between the WCHS and IVPB for a CDC webinar, Highlighting Public Health Contributions to Violence Prevention. Next, through a collaborative effort between WCHS, IVPB, and the Office of the Chief Medical Examiner (OCME), IVBP was awarded grants from the CDC and a local foundation to support work on development of a NC child maltreatment surveillance system. The IVPB included child sexual abuse (SA) as one of the state priorities in the Sexual Assault Prevention Plan. Staff from WCHS and IVPB are members of an advisory board for the primary prevention of child SA. An education webinar regarding the effects of child maltreatment on brain

development was provided to staff in the C&Y Branch which facilitated an understanding of the public health role in identifying situations of maltreatment (e.g., during home visits with hearing impaired children or as a school health nurse).

Design work with NIRN to implement the MIECHV Program and develop state leadership for NFP and HFA continued. An RFA was issued to expand home visiting in NC via MIECHV. Four models were identified in the state needs assessment. As a result of the RFA, 2 new NFP sites, 1 new HFA site, 2 expansion sites of NFP and 1 expansion site of HFA were funded through MIECHV.

The evidence-based program Family Strengthening awards for Incredible Years and Strengthening Families Programs (SFP) made by C&Y Branch concluded their second year of funding in May. It is important to note that these programs were part of the Alliance. The Alliance has developed a shared infrastructure for supporting IY and SFP 6-11. Outcome data from these awards were very positive. Findings for the data analyzed of families completing the IY Parent Series in NC in FY11 showed statistically significant results in the following areas: increase in parental appropriate discipline practices, positive parenting practices, and clear expectations of the child's behavior, and decrease in children's problematic behavior and parents' inconsistent and harsh discipline practices. Findings for the data analyzed of families completing the SFP 6-11 in NC between in FY11 showed statistically improvement in parental involvement, parental supervision, parenting efficacy, positive parenting, family cohesion, family communication, family strengths and resilience, family organization, child's concentration, and child's social behavior. Declines were noted in the areas of family conflict, child's depression, child's overt aggression, and child's covert aggression. Effect sizes were equal to national norms and significantly higher than SFP child abuse prevention norms.

DPH continued to participate in the Strategic Framing Learning Community. The goal of this project is to continue developing capacity within NC by convening and supporting select state and local level agencies who wish to gain the knowledge, skills and experience to later provide training and technical assistance within their agencies and to allied stakeholders in NC. Several additional branches such as IVP and EI sought technical assistance from this project.

Participation with the CDC Public Health Leadership Initiative (PHL) continued. This is a 3-year project to identify best practice models of state public health leadership in CMP. NC was identified as one of five "model" states and the CMPLT ED participated on a panel to test the toolkit.

The CFTF recommended funding for the Child Treatment Program to train and support clinicians in delivering proven-effective, time-limited services to children and their families to address trauma and restore funding to the OCME for fatality surveillance. The Period of PURPLE Crying Program has been incorporated into LHDs in 81 of 100 counties.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued implementation of the Adolescent Parenting Program Projects.		X		
2. Continue training professionals and public awareness activities for the Infant Homicide Prevention Act.			X	
3. Assist with implementation of Task Force on Child Maltreatment Recommendations.				X
4. Continue collaboration with NC Parenting Education Network.				X
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

DPH continues to develop capacity for CMP leadership and integrate CM as a public health issue. A UNC researcher is developing a Wake County surveillance system to inform the state system. The CDC-funded position has not been hired due to budget issues. The NC MIECHV program held a two-day grantee meeting with HFA and NFP sites and state-level stakeholders to support home visitors in conducting parenting education and reducing family stressors. The NC MIECHV Program provided trainings for HFA sites in data and model fidelity. Young Moms Connect provided trainings for all PAT and HFA sites. The CFTF convened stakeholders including PURPLE, breastfeeding, and smoking cessation to coordinate messages to new parents in hospitals. Child death scene investigation was incorporated into Basic Law Enforcement Training to improve collection of information relating to child abuse and neglect (as well as SIDS and other child death issues). Funding was secured through DSS for a Child Treatment program to help children overcome traumas. Researchers and practitioners met about newborn screening tool predicting child abuse and domestic violence exposure with more than 90% accuracy. The ECCMPLT participated in a Casey Family Programs forum to reduce child fatalities and increase child wellbeing. All Adolescent Parenting Program coordinators have been trained to use either Partners for a Healthy Baby or PAT for home visiting. DPH will be featured in a CDC PHL webinar in May.

c. Plan for the Coming Year

Capacity development for child maltreatment prevention leadership will continue. WCHS/IVP will also continue the work with collaborative partners in the area of domestic violence and Child Maltreatment Prevention (CMP), the expansion of universal/selective CMP efforts, and increased training/awareness on child abuse and neglect reporting laws (focus on health professionals and educators), including the feasibility of a centralized reporting system. The C&Y Branch will continue implementation of Project LAUNCH and coordinate activities with CMP, ECCS, CFTF, and evidence-based parenting programs. Via LAUNCH, the C&Y Branch will implement Triple P. Project LAUNCH will inform service delivery throughout NC.

WCHS, via the NC Framing Learning Community, will continue work toward movement from the "child maltreatment prevention frame" to the CDC frame of "supporting safe, stable, and nurturing relationships" and the frame of "promoting healthy brain development" in an effort to build more collaborative partners and gain broader support for family strengthening programs. WCHS will work with the DPH social marketing program to produce materials. The CMPLT ED will present at several regional and national conferences.

A data sharing agreement has been entered with DPH/DSS for CM data for APP data. APP is planning to implement a validated scale in FY13 as well as planning to implement either the Adult-Adolescent Parenting Inventory (AAPI-2) or the Protective Factors Survey (PFS) with the APP participants in FY13.

The CFPT will provide Safe Surrender Workshops and educational materials to community partners. Safe Surrender will continue to be a priority.

An emerging opportunity is through NC DHHS Excels. The mission statement of Excels is: NC DHHS, in collaboration with its partners, protects the health and safety of all North Carolinians and provides essential human services. The CMPMT ED has been named as the leader of goal 3: Provide outreach, support and services to individuals and families identified as being at risk of compromised health and safety to eliminate or reduce those risks.

State Performance Measure 2: *The number of children in the State less than three years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	15040	15500	15700	16000	18000
Annual Indicator	15048	15869	17606	18271	19523
Numerator					
Denominator					
Data Source		EI Branch CECAS	EI Branch CECAS	EI Branch CECAS	EI Branch CECAS
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	19523	19523	19523	19523	19523

Notes - 2011
Manual indicator (count) is used in this state performance measure.

Notes - 2010
Manual indicator (count) is used in this state performance measure.

Notes - 2009
Manual indicator (count) is used in this state performance measure.

a. Last Year's Accomplishments
Quality improvement continued, focused on increasing consistency in access to resources for infants and toddlers with or at established risk for developmental disabilities, and their families. Expected changes in federal regulations did not occur.

The Early Intervention program continues to increase in enrollment of infants and toddlers. Monthly data on numbers of children enrolled on the first day of the month increased by 2% across the fiscal year (July 1 2010 to June 1 2011). Continued increases are expected.

The program has used American Recovery and Reinvestment Act (ARRA) funding to focus on providing services and accessing professional development for the improvement of services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued implementation of state level monitoring system.				X
2. Collection of referral and enrollment data on a monthly basis.				X
3. Increase in number of enrolled children.	X			
4. Development and implementation of State Performance Plan (SPP).				X
5. Public reporting on all data from SPP at local and state levels.				X

6. Continued examination of and improvement in efficiency and effectiveness.				X
7.				
8.				
9.				
10.				

b. Current Activities
A statewide workgroup and committees completed recommendations for increasing consistency in access for enrolled children and their families. A statewide list of eligibility evaluation tools and an intake script to use with families whose children are two examples.

The Program has implemented the Health Information System (HIS) database. The primary focus of this implementation has been on financial data collection and reimbursement. Reports and programmatic elements continue to be reviewed for implementation.

Policy changes on fees and billing as well as assistive technology were implemented statewide. The State Performance Plan and Annual Performance Report were completed. Use of ARRA funding for services and professional development were completed; time limited positions continued through the first quarter of 2011-2012.

A federal site visit resulted in a minor change in the mediation policy and planning for piloting a results-focused strategy to improve outcomes for families. Response to the federal site visit letter will be completed in April 2012, with the mediation policy change memo dissemination and implementation.

Statewide public awareness events using ARRA funds were completed. Publications and public awareness materials were printed and distributed.

Federal regulations were revised for the Early Intervention program, and released in September 2011. Policy changes to reflect the new regulatory language were proposed for public comment February -- April 2012.

c. Plan for the Coming Year
Implementation planning for workgroup/committee recommendations began with an examination of eligibility tools and purchases will be completed. Training on tools, for staff who are not already trained and using them, will be planned and implemented in 2012-2013. The intake script is finalized, and implementation plans for dissemination and use will be completed.

Professional development funding continued with carry forward funding from the federal grant, in order to continue the efforts initiated under ARRA funding. Revised federal regulations have a specific focus on evidence based practice and scientifically based research, so a revision of the Comprehensive System of Personnel Development is needed.

The Program's database, the Health Information System (HIS) will continue to be reviewed for further implementation for programmatic elements. Programmatic data reports were incomplete, due to issues with the vendor for the database development. All programmatic data fields are uploaded to a Client Services Data Warehouse (CSDW) where queries can be written to run reports. Ideally, HIS and CSDW will provide a management tool, electronic child record and service coordination management tool.

The federal funding agency announced plans to focus on performance rather than compliance, so new performance indicators are expected. Revisions to monitoring and performance strategies will be needed.

Statewide public awareness specifically for finding and enrolling infants (< one year of age) who have or are at established risk for developmental disabilities or delays will be planned and implemented.

Implementation of any policy changes as a result of the revised federal regulations and public comment will be planned during the fiscal year, with priorities on changes that have the greatest potential positive impact for children and families.

State Performance Measure 3: *Percent of children 2-18 who are obese. Obese is defined as a body mass index (BMI) greater than or equal to the 95th percentile for gender and age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	14	13	12	10	15
Annual Indicator	17.4	17.3	17.5	18.0	16.1
Numerator	20062	20863	19295	15341	17647
Denominator	115394	120472	110406	85238	109925
Data Source		NC-NPASS	NC-NPASS	NC-NPASS	NC-NPASS
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	15	15	15	15	15

Notes - 2011
The data source is NC Nutrition and Physical Activity Surveillance System (NC-NPASS) which includes data from children who participate in Child Health and WIC in local health departments and children in School Based/School Linked Health Centers.

FY year data are actually the prior calendar year, e.g. FY11 is really CY10.

Notes - 2010
The data source is NC Nutrition and Physical Activity Surveillance System (NC-NPASS) which includes data from children who participate in Child Health and WIC in local health departments and children in School Based/School Linked Health Centers.

FY year data are actually the prior calendar year, e.g. FY10 is really CY09.

Notes - 2009
The data source is NC Nutrition and Physical Activity Surveillance System (NC-NPASS) which includes data from children who participate in Child Health and WIC in local health departments and children in School Based/School Linked Health Centers.

FY year data are actually the prior calendar year, e.g. FY09 is really CY08.

a. Last Year's Accomplishments
The percentage of children ages 2 to 18 years receiving WIC services with a Body Mass Index at or above the 95th percentile remained at 18% in CY11. Efforts undertaken by the NSB and C&Y Branch in FY11 to help reduce this percentage included the following activities:
-offered the Pediatric Nutrition Course to local agency staff and private providers;
-provided nutrition education training and resources for the 106 schools participating with the USDA Fresh Fruit and Vegetable Program (FFVP);

-provided training on staff wellness toolkit, "Serve Up a Healthier You", for Child Nutrition professionals;
-provided full course workshop for "Smart Options" certification training for Child Nutrition professionals;
-evaluated the "Smart Options" training;
-developed resources and provided training to school staff on accommodating students with special nutritional needs;
-developed "Breakfast is Brain Fuel" school breakfast promotional toolkit;
-developed and promoted toolkits and resources to support implementation of local wellness policy in schools, provide nutrition education, and promote school meals as the healthy, low cost choice; and
-provided training to school staff on accommodating students with special nutritional needs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhancement of Nutrition and Physical Activity Surveillance System (NC-NPASS).				X
2. Education of health care professionals/staff training.				X
3. Education of children and their parents/caretakers.		X		
4. Continuation and expansion of Nutrition and Physical Activity Self Assessment for Child Care.				X
5. Implement WIC program policies supportive of dietary change.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In FY12, the NSB and C&Y Branch are continuing these activities in an effort to reduce childhood overweight and obesity:
-offering the Pediatric Nutrition Course to local agency staff and private providers;
-providing nutrition education training and resources for the 170 schools participating with the USDA FFVP;
-providing train the trainer and full course workshop for "Smart Options" certification training for Child Nutrition professionals;
-developing resources and providing training to school staff on accommodating students with special nutritional needs;
-providing training on "Breakfast is Brain Fuel" school breakfast promotional toolkit; and
-developing and promoting resources to support implementation of local wellness policy in schools, provide nutrition education, and promote school meals as the healthy, low cost choice.

Additional activities include:
-developing a school garden toolkit;
-presenting at six regional child health nurse consultant trainings on AAP's Bright Futures Nutrition and Assessment; and
-providing three webinars for NC School Health Nutrition Network and the NC Dietetic Association on the SPARK program, Hunger & Obesity, and Medical Nutrition Therapy Reimbursement.

c. Plan for the Coming Year
The NSB and C&Y Branch plans to conduct the following activities in FY13:
-offer the Pediatric Nutrition Course to local agency staff and private providers;

-provide nutrition education training and resources for schools participating with the FFVP;
-provide Train the Trainer and full course workshops for "Smart Options" certification training for Child Nutrition professionals;
-continue development of a school garden toolkit;
-develop resources and provide training to school staff on accommodating students with special nutritional needs; and
-develop and promote resources to support implementation of local wellness policy in schools, provide nutrition education, and promote school meals as the healthy, low-cost choice.

State Performance Measure 4: *The percent of women responding to the Pregnancy Risk Assessment Monitoring System (PRAMS) survey that they either wanted to be pregnant later or not then or at any time in the future.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	39	38	38	38	39
Annual Indicator	47.6	39.8	43.9	44.6	45.2
Numerator					
Denominator					
Data Source		Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	40	40	40	40	40

Notes - 2011
Data are for CY10. PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

Notes - 2010
Data are for CY09. PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

Notes - 2009
Data are for CY08. PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

a. Last Year's Accomplishments
Updated 2010 data from PRAMS show that 45.2% of pregnancies were unintended. This is a 13 percent increase from the CY07 rate of 39.8 %, which was the lowest ever reported through PRAMS and an increase from the 2009 rate of 44.6%. The most recent unintendedness rate is also higher than the 2010 objective (43%) in the Logic Model adopted by the WHB.

The Family Planning and Reproductive Health Unit (FPRHU) of the WHB continues to provide comprehensive family planning services through a network of approximately 140 service sites throughout the state. These sites served 125,230 unduplicated patients in CY11. This number represents a significant decrease (11.8% or 14,752 fewer patients) compared to the previous year's total of 139,982. Over the past ten years, this is the steepest decline in patient numbers compared to the previous year. While part of the decline can be attributed to actual service delivery reductions due to staff shortages and other local issues, a significant portion of the decline has been attributed to underreporting of unduplicated patients and delayed reimbursement claims as DPH transitioned to a new data reporting and billing system beginning in February 2009.

The implementation of an outreach and marketing initiative designed specifically to increase patients numbers in 26 targeted LHDs which began four years ago is continuing for another three-year cycle. This initiative has significantly contributed to the increase in patient numbers among the participating agencies, but not enough to offset the decline noted above.

In 2008, the FPRHU revised the funding formula for distributing State Women's Health Service Funds that supplement the cost of contraceptives. The revised formula provides additional incentives for local agencies to promote the use of Long Acting Reversible Contraceptives (LARC) such as Intrauterine Device (IUD), 3-month hormonal injection, hormonal implant, contraceptive patch, and vaginal ring. Most recent CY11 data from the Family Planning Annual Report (FPAR) show that 46% (57,505) of all women who are contracepting are using the more effective reversible methods compared to 44% in CY10. Use of LARC has been strongly associated with reduction in unintended pregnancy rates.

The distribution of other methods, such as vaginal rings and contraceptive patches, has remained relatively constant while the numbers of IUD and hormonal implant users continue to increase. However, the number of teens using hormonal injections declined by 24%, based on FPAR data from CY10 (7,032 teens) and CY11 (5,672 teens). This decline may be a function of an overall declining trend in teen patient enrollment in the past five years.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Proceed with either a renewal of the 1115(a) Medicaid demonstration waiver, or the State Plan Amendment option with expanded service delivery requirements (support for transportation services) or target population, including teens				X
2. Continuation and expansion of the Hispanic/Latino Outreach Initiatives.		X		
3. Continuation and expansion of special outreach initiatives, particularly to teen patients.		X		
4. Continuation of sterilization funding and services.				X
5. Continuation of TPPI, with greater emphasis on programs for Hispanic/Latino youth.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2011 the FPRHU began the transition of a 1115(a) Medicaid demonstration waiver to a State Plan Amendment (SPA). The SPA will continue to extend eligibility for family planning services to

women (age 19-55) and men (age 19-60) with incomes =< 185% of the FPL, as well as providing services to teens. The major goals of the waiver are to reduce unintended pregnancies and improve the well being of children and families in NC. The waiver status was extended through June 2012 as the FPRHU and the DMA finalize their decision.

The increase in the Hispanic population in NC continues to be a challenge for local maternal health and family planning clinics. To help meet this challenge, the FPRHU funds the Latino Family Planning Outreach Initiative with $500,000 in special Title X funds for projects in communities with large Latino populations. In CY11, four local health departments were awarded funds, the first time health departments became eligible for funding, increasing the number of projects to seven, with three community based organizations. The FPRHU is also implementing the action steps prescribed in DPH's Recommendations for Eliminating Health Disparities.

The FPRHU received another three-year (FY11-13) Special HIV Integration Grant from the Office of Population Affairs used to increase HIV testing in the family planning clinic setting. The additional funding allowed the FPRHU to expand the initiative to four counties.

c. Plan for the Coming Year

The FPRHU and DMA in the process of transitioning the 1115 Medicaid Waiver to the State Plan Amendment option with expanded service delivery requirements (support for transportation services) or target population, including teens. Two objectives of the waiver specifically target reductions in the number of inadequately spaced pregnancies and the number of unintended and unwanted pregnancies among women eligible for Medicaid.

In response to the declining patient census, the FPRHU will continue to implement and evaluate the outreach and marketing initiative in FY12, with an eye towards identifying best practice models that may be replicated in other local health departments, given additional funding, as well as defunding projects that do not meet the stated objectives after the first three-year cycle. This is a priority activity for the FPRHU in light of the significant decline in patient census this year. Quality improvement, and quality assurance initiatives, as well as improving clinic efficiency, are also major initiatives to improve quality of care, and patient census.

Regional Consultant staff reorganization due to a number of staff retirements will continue to be refined, and activities and responsibilities will be redistributed as the Medicaid waiver and other initiatives are implemented. Accountability issues will continue to be a major focus. Specifically, local agency contracts which include program specific process and outcome objectives will be assessed more systematically. In addition, the results of regularly scheduled clinical Quality Assurance Monitoring will be analyzed more carefully to determine their impact on clinical practice, training needs, and future policy changes, etc. TPPI will continue to expand with the restoration of TANF funds. This is significant in light of the high rates of out-of-wedlock births and recent increases in unintended pregnancy rates among teens.

State Performance Measure 5: *Percent of women of childbearing age taking folic acid regularly.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	50	50	50	50	50
Annual Indicator	29.2	38.3	38.3	42.6	42.6
Numerator					
Denominator					
Data Source		NC	NC	NC	NC

		BRFSS	BRFSS	BRFSS	BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	50	50	50	50

Notes - 2011
2011 BRFSS data are not yet available, thus the data for 2010 is repeated here. As the folic acid questions have changed from prior years, data for 2007 and beyond are not comprable to data from previous years.

Notes - 2010
As the folic acid questions have changed from prior years, data for 2007 and beyond are not comprable to data from previous years.

Notes - 2009
These data are for CY2008 from the BRFSS. Data for 2009 are not yet available. As the folic acid questions have changed from prior years, data for 2007 and beyond are not comprable to data from previous years.

a. Last Year's Accomplishments
Data from the NC Behavioral Risk Factor Surveillance System (BRFSS) indicated that in 2001, 42.2% of women of childbearing age (15-44 years) in NC took folic acid regularly. This percentage jumped to 47.1% in 2004, but then decreased to 38.5% in 2006. More recent trend data for this measure are not available as the questions used in the NC BRFSS have changed over the years. Using the new questions, NC BRFSS data for 2007 indicated that only 29.2% of women aged 18 to 44 were currently taking a multivitamin containing folic acid at least 5 times per week. This increased to 38.3% in 2008 and 42.6% in 2010.

The NC Folic Acid Council officially transitioned to the NC Preconception Health Campaign and unveiled its new logo. While folic acid education continued to be the primary emphasis, the promotion of healthy weight for women in accordance with the strategic plan was added. This includes the development of an evidence-based health care provider curriculum about healthy weight and consumer materials for women of childbearing age.

In collaboration with the March of Dimes Foundation the following activities were also implemented:
- Statewide multivitamin distribution program: A program to distribute multivitamins to low-income women was continued via the purchase of additional multivitamins, ongoing technical assistance and the availability of an online training module for new providers across the state that began to distribute multivitamins as part of this program. This effort provided assistance for all 234 agencies participating in the program and 80,817 bottles were shipped to agencies that serve low-income women of childbearing age.
- Health care provider training: 1,201 health care providers were trained about folic acid in clinical settings via the Office Champion Program and at other outreach opportunities such as exhibits at health care provider conferences.
- Community education: A total of 80 Community Ambassadors were trained to reach their peers with one-on-one folic acid education. Together these Community Ambassadors reached more than 4,000 women around the state.

The WHB partnered with the Office of Minority Health National Center to sponsor the Preconception Peer Education Training Program (PPE) in the fall of 2010. The PPE goal is to reach the college-age population with targeted health messages emphasizing preconception health and healthcare. Forty-seven students were trained as certified preconception peer educators. Six universities have built active PPE programs on their campuses. Four other schools have incorporated the activities into their general peer education efforts.

Folic acid consumption is a priority area for Healthy Beginnings and education is provided during home visits or during the monthly contact. Sites do not provide folic acid to participants but direct them to their health care provider. If no or low cost vitamins are available in their community, participants are referred to those sources.

The NSB continued to require that local WIC staff provide education to postpartum women on the importance of folic acid.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Education of health care professionals via a variety of strategies.				X
2. Education of consumers and reminders to take a multivitamin daily.			X	
3. Mass media and public awareness activities.			X	
4. Distribution of multivitamins with folic acid to low income non-pregnant women.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Folic acid education continues to be part of a bundled preconception health message for all women of childbearing age. At least 1,704 providers have been reached through trainings. Folic acid education for consumers has been weighted heavily toward Spanish-speaking women of childbearing age, as they are at highest risk for neural tube defects (NTD). The community ambassador program has been particularly effective. Fifty lay health educators have been trained to teach their peers about the importance of folic acid reaching 1,117 women. These efforts worked synergistically with a federal CDC grant in Mecklenburg County that allowed for direct one-on-one folic acid education for Hispanic women. Decreasing NTD rates in this population over the last five years indicate that healthy equity is an achievable goal.

The statewide multivitamin distribution program continues via ongoing technical assistance and an online training module for new providers across the state. 2,029 bottles of vitamins were shipped to 62 agencies serving low-income women of childbearing age.

WHB continues to support the 10 universities originally trained through the PPE program.

The NSB continues education through the WIC Program on the importance of folic acid for women who may become pregnant. The NSB will pilot the Women's Nutrition and Wellness Course for local health agency staff.

A folic acid lesson plan for high school students was developed and introduced in classrooms and to teacher organizations.

c. Plan for the Coming Year

Pending legislative funding, the Campaign will continue to provide health care provider and consumer education using the regional coordination model, media to promote folic acid among consumers, the high school curriculum, and the multivitamin distribution program. The emphasis

on Hispanic women will continue, as we have seen promising results in addressing this health disparity.

The WHB will hold the Birth Matters: Best Practices to Improve Pregnancy Outcomes and Family Health Conference in August 2012. It is anticipated that folic acid use might be a topic in one of the concurrent sessions.

The NSB plans to continue education through the WIC Program on the importance of folic acid for women who may become pregnant. The NSB will also offer the Women's Nutrition and Wellness Course twice in FY13.

State Performance Measure 6: *The ratio of school health nurses to the public school student population.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	1200	1200	1150	1150	1100
Annual Indicator	1,340.8	1,225.4	1,206.6	1,185.3	1,201.4
Numerator	1386363	1404957	1410497	1402269	1409895
Denominator	1034	1146.5	1169	1183	1173.5
Data Source		NC Annual School Health Services Report 2007-08	NC Annual School Health Services Report 2008-09	NC Annual School Health Services	NC Annual School Health Services
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1100	1100	1100	1100	1100

Notes - 2011
As colons are not allowed in the measure, the number listed in the objectives is the second number of the ratio (1:1225.4, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY07 Students: 1,386,363 School Nurse FTEs: 1034; ratio 1:1341
FY08 Students: 1,404,957 School Nurse FTEs: 1146.5; ratio 1:1225.4
FY09 Students: 1,410,497 School Nurse FTEs: 1169.04; ratio 1:1207
FY10 Students: 1,402,269 School Nurse FTEs: 1183.36; ratio 1:1,185
FY11 Students: 1,409,895 School Nurse FTEs: 1173.5; ratio 1:1,201

Notes - 2010
As colons are not allowed in the measure, the number listed in the objectives is the second number of the ratio (1:1225.4, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY06 Students: 1,363,695 School Nurse FTEs: 867.9; ratio 1:1571
FY07 Students: 1,386,363 School Nurse FTEs: 1034; ratio 1:1341
FY08 Students: 1,404,957 School Nurse FTEs: 1146.5; ratio 1:1225.4
FY09 Students: 1,410,497 School Nurse FTEs: 1169.04; ratio 1:1207
FY10 Students: 1,402,269 School Nurse FTEs: 1183.36; ratio 1:1,185

Notes - 2009
As colons are not allowed in the measure, the number listed in the objectives is the second number of the ratio (1:1225.4, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY06 Students: 1,363,695 School Nurse FTEs: 867.9; ratio 1:1571
FY07 Students: 1,386,363 School Nurse FTEs: 1034; ratio 1:1341
FY08 Students: 1,404,957 School Nurse FTEs: 1146.5; ratio 1:1225.4
FY09 Students: 1,410,497 School Nurse FTEs: 1169.04; ratio 1:1207

a. Last Year's Accomplishments
At the end of FY11, there were 322.75 state funded school nurse positions (235.75 through the School Nurse Funding Initiative [SNFI], and 87 through the Child and Family Support Team [CFST] Initiative). All school nurse positions in the state totaled 1173.50. The SNFI numbers increased by 10 through legislation that had been enacted in FY10. The school nurse to student ratio at end of FY11 was 1:1201, 16 higher than FY 2010. The increase in ratio was related to minor drop in local positions and an increase of 7,500 students. The trend over the past 12 years has consistently reduced nurse to student ratio, from 1 nurse per 2,450 students in 1998.

The 2010 School Health Program Manual and the 2009 Emergency Guidelines for Schools was revised and printed by DPI in collaboration with DPH in time for the start of the school year. The 2009-2010 NC Annual School Health Services (ASHS) Report was posted on the health and education websites winter 2011. The report was distributed to school health providers and stakeholders, key decision-makers in local and state government, advocates for school health, and the media.

The school nurse case management project, formed in collaboration with East Carolina University School of Nursing through a grant of the Katherine B. Reynolds Trust, concluded during SY11. Four training conferences were held and a final wrap-up event was held in May 2011.

The regional School Nurse Consultants (SNCs) gathered data from public schools about the care of students with diabetes in compliance with a legislative mandate. The data were analyzed and a report was provided to DPI and presented to the State Board of Education in October 2010. The analysis of the data indicated deficiencies by most charter schools and compliance by 98% of non-charter public schools. The State Board of Education directed staff to work to educate charter schools about the law, and this mandate was carried out by DPI staff as well as the DPH SNCs.

The state and regional SNCs participated in the second year of the CHIPRA grant pilot project lead by the NC Pediatric Society to increase utilization of the Kindergarten Health Assessment (KHA) and improve the enrollment of 5-year-olds in health insurance.

More than 500 school nurses attended the 27th Annual School Nurse Conference October 2010. The conference steering committee is composed of all the SNCs and staff from the UNC Institute

for Public Health and in consultation with local school nurses.

The SNCs developed and coordinated with Northwest Area Health Education school nurse certification review course in the mid-western area of the state. About two dozen school nurses took the course in preparation for meeting state-mandated national certification in school nursing.

The state SNC served as the DPH staff member in the statewide Modified Diets Task Force and, with others, delivered training to almost 500 school staff in 8 regional locations.

The state SNC assessed the client satisfaction surveys completed by school staff about each regional SNC that conducted a site visit, and the review provided suggestions for developing additional professional development events and in-service education for school nurses.

All the SNC's participated at times in the School Health Matrix meetings throughout the school year, and all SNCs participated in an annual consultative meeting with the NC Board of Nursing in June 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of program agenda for Annual School Nurse Conference and other continuing education offerings.				X
2. Clinical and administrative consultation, training and technical assistance to school districts, local health departments, and hospitals.				X
3. Collection and analysis of data regarding health needs, resources and program services.				X
4. Development of standards, guidelines and procedures.				X
5. Dissemination of new nursing and school health related information.				X
6. Collaboration with families and at least five other stakeholders in school health outside of the Division, school districts, and health departments.				X
7.				
8.				
9.				
10.				

b. Current Activities

There are currently 314.75 (235.75 SNFI, 79 CFST) state funded school nurse positions. The interim (mid-year) FY12 estimate of all school nurse positions is 1197.47, an increase of 24, and a ratio of 1:1190, a drop of 11. The number of SNFI increased by 10; cuts to the CFST program resulted in 9 fewer CFST nurses.

SNCs continue to work with the NC Pediatric Society's project assuring child enrollment in insurance.

The SNCs are assisting two Area Health Education Centers (AHECs) to provide two school nurse certification courses (in western & eastern regions of the state).

The SNCs gathered data and issued a report to NC Board of Education in October 2011 demonstrating 100% compliance by public schools with most components of state law about students with diabetes.

The SNCs coordinated and presented at the 29th Annual School Nurse Conference, attended by 485 in October 2011.

The SNCs collected service and activity data from school year 2010-11, including outcome date revealing positive student health and quality of life outcomes directly related to school nurse interventions. The information is included in the SY10-11 ASHS report, released and posted to the DPH website in January 2012. The report was distributed to school health providers and stakeholders, key decision-makers in local and state government, advocates for school health, and the media. The 2010 edition of the School Health Program Manual was reviewed for updates, and the updates were released to DPI for publication.

c. Plan for the Coming Year

School nurse staffing levels will be heavily influenced by actions of the NC General Assembly in the summer of 2012. State and local budget cuts or changes in the methods of allocation of funding may result in more or fewer school nurse positions. In 2011, the legislature eliminated the cap on publicly funded charter schools and authorized "fast track" approval of new charter applications, resulting in nearly 10% more charter schools during next school year. Without changes in the legislation this summer, the number of charter schools may rise exponentially each year. The administrators of these schools, about a third of which currently employ school nurses, will need training on NC's laws regarding care of CSHCN, including the mandated provision of diabetic care managers to those students.

The state and regional SNCs will continue to provide assistance in carrying out the objectives of the school nurse program locally and statewide. Activities related to that goal are: continued service on committees that affect school health, continued consultation and provision of technical assistance to school personnel, and review of continuing education opportunities and professional development of school nurses and school health program administrators.

The state SNC will continue to assess the client satisfaction surveys completed by school personnel about regional SNCs and will offer the C&Y Branch suggestions for revising the form and the method of collection.

The state SNC will maintain a partnership with the School Health Matrix Team and the additional dozen or more collaborative associations that result in cross-disciplinary and cross-agency improvement in the care of students with special health needs.

The state and regional SNCs will continue to collect service and activity data from the school nurses, with emphasis on data and activities that result in improved student health and academic outcomes.

Through continued partnership with the regional AHECs, the consultants will work to increase quality indicators of school nurse workforce, including the number and percent that are nationally certified in school nursing (a state mandated) and who hold advanced degrees.

The SNCs will continue to promote the concept of intensive school nurse management of students with complex and chronic health conditions as a continuation of the program developed during the ECU/Reynolds Trust project that began five years ago. The SNCs will incorporate the best practices learned that project and disseminate information statewide through individual consultations, regional conferences and/or group technical assistance for school nurses working with students with complex, chronic conditions.

SNCs will provide technical assistance to nurses working in the School-Based/School-Linked Health Centers and the CFST program, as well as to those serving CSHCN in the state's charter and private schools.

State Performance Measure 7: *Percent of women with live, term births who gain within the Institute of Medicine (IOM) Recommended Weight Gain Ranges.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	35	36	37	38	38
Annual Indicator	32.9	34.0	31.8	31.9	30.5
Numerator	12959	15642	15835	15101	17904
Denominator	39331	45960	49872	47344	58647
Data Source		NC Pregnancy Nutrition Surveillance System(NCPNSS)	NC Pregnancy Nutrition Surveillance System(NCPNSS)	NC Pregnancy Nutrition Surveillance System(NCPNSS)	NC Pregnancy Nutrition Surveillance System(NCPNSS)
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	35	35	35	35	35

Notes - 2011
Data are based on prior CY (FY11 is really CY10). As per the detail sheet, these data are only available for women receiving WIC services.

Notes - 2010
Data are based on prior CY (FY10 is really CY09). As per the detail sheet, these data are only available for women receiving WIC services.

Notes - 2009
Data are based on prior CY (FY09 is really CY08). As per the detail sheet, these data are only available for women receiving WIC services.

a. Last Year's Accomplishments
Activities for FY11 included continued education about the revised gestational weight gain guidance and the importance of a healthy weight during pregnancy as well as continued promotion of the revised maternal health clinic flow sheet to increase attention to women gaining outside of the IOM gestational weight guidelines. Educational efforts included a webinar training on the 2009 IOM guidelines for recommended weight gain during pregnancy provided by the NSB to nutrition and nursing staff in local public health agencies. The NSB developed new prenatal weight gain charts to reflect the new prenatal weight gain guidelines; nutrition staff are required to use the new charts to assess weight gain during pregnancy for pregnant women enrolled in the WIC Program. Another NSB webinar training was provided to local agency WIC nutrition staff to further address the application and use of the WIC Nutrition Assessment and Care Plan to document nutrition assessments and development of care for pregnant women. Healthy weight in pregnancy promotion and guidance was also extended beyond local health department maternity

clinics and included community based organizations working with prenatal women in programs which also have a lifestyle behavior component (e.g. Healthy Beginnings and Baby Love Plus projects).

The NSB continued to provide 10-year trend data on the number and percent of women who receive WIC Program services during pregnancy and who gain inadequate/recommended/excessive weight according to the 2009 IOM guidelines. The WIC Program continued to provide nutrition education to prenatal participants on prenatal weight gain. The NSB, in collaboration with UNC-Chapel Hill, began developing an online Women's Nutrition and Wellness Course for local public health staff.

In the WHB, revised BMI wheels were developed and include the IOM gestational weight gain guidance chart printed directly on the wheel to remove the need to use both a wheel and a chart to assess weight gain during pregnancy. An increased focus on Gestational Diabetes has led to the development of a consumer fact sheet which includes a "healthy weight gain during pregnancy" message.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Staff training.				X
2. Client education and awareness.		X		
3. Anthropometric data collection and assessment.	X			
4. Data analysis.				X
5. Monitoring/surveillance of prenatal weight gain				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In early FY12, the WIC nutrition risk criteria were revised to more closely reflect the federal standards. WIC nutrition staff currently use the revised nutrition risk criteria when determining risks for nutrition eligibility and counseling needs while conducting nutrition assessments. The WIC Program continues to provide nutrition education to prenatal participants on prenatal weight gain. The NSB continues to provide 10-year trend data on the number and percent of women who receive WIC Program services during pregnancy and who gain inadequate/recommended/excessive weight according to the 2009 IOM guidelines. The NSB is in the process of developing a new computer system which will provide electronic plotting capability. The NSB is developing and piloting the Women's Nutrition and Wellness Course for local health agency staff.

Ongoing education about gestational weight gain guidance and the importance of a healthy weight during pregnancy is provided to health care professionals by WHB staff members. In addition, during high-risk maternity clinic patient record monitoring, attention is paid to documentation and patient education about appropriate gestational weight gain. The BMI/gestational age wheels have been distributed to health care providers who have participated in the "Healthy Weight Matters" in-office and large-group trainings.

c. Plan for the Coming Year

In FY13, the WHB plans to develop a printed educational piece for consumers explaining the rationale for appropriate weight gain during pregnancy and highlighting the current gestational

weight gain recommendations. The WHB will hold the Birth Matters: Best Practices to Improve Pregnancy Outcomes and Family Health Conference in August 2012.

Activities planned for the NSB for FY13 include the continued use of the revised WIC nutrition risk criteria. With the impending implementation of a new computer system for processing WIC enrollments, the nutrition risk codes used for WIC nutrition eligibility will be converted to the federal coding system. This conversion will improve the synchronicity with the federal coding system and allow for stronger comparisons with national data sets. The system will automatically calculate pre-pregnancy BMI, plot and track prenatal weight gain and identify risk criteria which will assist staff in providing appropriate care and state tracking of changes in pregnancy weight gain trends for women. The NSB will also offer the Women's Nutrition and Wellness Course twice in FY13.

State Performance Measure 8: *Percent of non-pregnant women of reproductive age who are overweight/obese (BMI>26).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	44	43	42	41	56
Annual Indicator	46.7	53.7	54.1	55.1	51.2
Numerator	21109	24242	26376	25942	30021
Denominator	45201	45143	48754	47082	58647
Data Source		NC Pregnancy Nutrition Surveillance System	NC Pregnancy Nutrition Surveillance System	NC Pregnancy Nutrition Surveillance System	NC Pregnancy Nutrition Surveillance System
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	55	55	56	56	56

Notes - 2011
Data are based on the prior calendar year. The data source is the North Carolina Pregnancy Nutrition Surveillance System (PNSS) which links data from the WIC program, public maternity clinics, birth certificates and fetal death certificates. Data are based on the 2010 IOM BMI and Weight Gain During Pregnancy Guidelines. Data from 2008 on are not comparable to data from previous years.

Notes - 2010
Data are based on the prior calendar year. The data source is the North Carolina Pregnancy Nutrition Surveillance System (PNSS) which links data from the WIC program, public maternity clinics, birth certificates and fetal death certificates. Data are based on the 2009 IOM BMI and Weight Gain During Pregnancy Guidelines. Data from 2008 on are not comparable to data from previous years.

Notes - 2009

Data are based on the prior calendar year. The data source is the North Carolina Pregnancy Nutrition Surveillance System (PNSS) which links data from the WIC program, public maternity clinics, birth certificates and fetal death certificates.

NOTE - Data have been revised using the 2009 IOM BMI and Weight Gain During Pregnancy Guidelines. Data from 2008 on are not comparable to data from previous years.

a. Last Year's Accomplishments
Health care provider offices were recruited to receive in-office provider education sessions about healthy weight in women. Participating offices received lunch and healthy weight education materials as incentives. This was done in partnership with the NC Preconception Campaign and based on the successful Office Champion education model used to educate health care providers about folic acid/multivitamin use for women of childbearing age.

In partnership with the MOD Foundation, a curriculum was developed for health care providers serving women of child bearing age in five high risk NC counties and addressed best practice topics, one of which is healthy weight.

Gestational Diabetes fact sheets for providers and patients have been developed and include related healthy weight messaging.

A health care provider curriculum entitled "Healthy Weight Matters" was developed for the Young Moms Connect (YMC) project and included evidence-based messages providers can share with women of childbearing age to achieve and maintain a healthy weight.

The NSB continued educational activities to support the WIC food packages for women participating in the WIC Program. Webinar training was provided to local agency WIC nutrition staff to further address the application and use of the WIC Nutrition Assessment and Care Plan form. The NSB continues to subscribe to an online client nutrition education system that includes modules titled "Preparing for a Healthy Pregnancy" and "Be Healthy as Your Baby Grows" which address healthy eating and being and staying active after delivery. The NSB, in collaboration with UNC-Chapel Hill, began developing an online Women's Nutrition and Wellness Course for local public health staff.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Client assessment.	X			
2. Client education.		X		
3. Staff training.				X
4. Data collection and assessment.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WHB activities include in-office provider education using the "Healthy Weight Matters" curriculum in both YMC and other counties. Trainings also include distribution of the revised BMI wheel and Healthy Weight Matters consumer workbooks. Both DPH and NCHSF now distribute the Healthy Habits workbook. A culturally-adapted Spanish language version of the healthy weight consumer workbook has been developed, along with a companion poster that includes the BMI chart for

consumers.

Healthy weight for women information has been added to the everywomannc.com website. A lesson plan for high school students about the importance of healthy weight for their health and their future is being introduced in classrooms across the state.

A new consumer piece for women of childbearing has been developed that, while touching on several preconception health topics, also includes a section on healthy weight that mirrors messages from existing pieces.

Both the Maternal Health Videoconference Series and the Building Bridges conference for health care professionals and/or community lay advisors included healthy weight presentations.

The NSB continues to emphasize assessment of and education about postpartum BMI, healthy weight, and nutrition and physical activity behaviors related to achieving a healthy weight. NSB continues to subscribe to the online client nutrition education system.

c. Plan for the Coming Year
FY13 WHB activities will include in-office provider education using the "Healthy Weight Matters" curriculum in both YMC and other counties. Trainings will also include distribution of the revised BMI wheel and Healthy Weight Matters consumer workbooks in both English and Spanish. The Spanish-language healthy weight booklet will be distributed throughout North Carolina.

The high school lesson plan about healthy weight will continue to be introduced in classrooms and to teacher's organizations across the state with the goal of having the lesson plan included in the NC Standard Course of Study.

A printed piece that addresses healthy weight throughout a woman's lifespan will be developed.

A comprehensive videoconference on gestational diabetes will be provided to health care professionals (in partnership with the NC Diabetes Prevention Branch) and will include healthy weight messaging.

Activities planned for the NSB for FY13 include the continued use of the revised WIC nutrition risk criteria. With the impending implementation of a new computer system for processing WIC enrollments, the nutrition risk codes will be converted to the federal coding system. This conversion will improve the synchronicity with the federal coding system and allow for stronger comparisons with national data sets. The system will automatically calculate BMI and identify risk criteria which will assist staff in providing appropriate care and state tracking of changes in weight trends for women. The NSB will also offer the Women's Nutrition and Wellness Course twice in FY13.

State Performance Measure 9: *Percent of children age 13 to 17 who have received 1 or more doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) since the age of ten years*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					90
Annual Indicator			28	54.7	67.7
Numerator					
Denominator					
Data Source			NIS-Teen	NIS-Teen	NIS-Teen

Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90	90	90	90

Notes - 2011
Data are from the National Immunization Survey - Teen for CY10. As this is a weighted estimate, data for the numerator and the denominator are omitted.

Notes - 2010
Data are from the National Immunization Survey - Teen for CY09. As this is a weighted estimate, data for the numerator and the denominator are omitted.

Notes - 2009
Data are from the National Immunization Survey - Teen for CY08. As this is a weighted estimate, data for the numerator and the denominator are omitted.

a. Last Year's Accomplishments
During FY11, contracted statewide deployment of the NCIR was completed, and 95% of NCIP providers are now using the NCIR. Increased provider participation in the NCIR will help to ensure that client immunization histories documented in the NCIR are complete. A new program evaluation project was initiated in January 2011 which will focus on the effectiveness of Adolescent AFIX visits which include reminder/recall training. A minimum of 60 Adolescent AFIX visits will be completed as part of the evaluation project.

According to the NIS data released in August 2011 for calendar year 2010, North Carolina's rate for adolescent ages 13-17 who had received one or more doses of Tdap was 67.7% giving North Carolina a ranking of 28th among the states and the District of Columbia. This was an increase of 13% from the 2009 rate of 54.7%. This rate is expected to continue to increase based on the establishment of Administrative Rule 10A NCAC 41A.0401 which states the following: A booster dose of tetanus/diphtheria/pertussis vaccine is required for individuals attending public school who are entering the sixth grade on or after August 1, 2008, if five years or more have passed since the last dose of tetanus/diphtheria toxoid. A booster dose of tetanus/diphtheria/pertussis vaccine is required for individuals not attending public schools who are 12 years of age on or after August 1, 2008, if five years or more have passed since the last dose of tetanus/diphtheria toxoid. However, pertussis (whooping cough) vaccine is not required for individuals between 7 years of age through the fifth grade for those attending public schools and 7 through 12 years of age for those not attending public schools.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Complete at least 50 Adolescent AFIX visits in calendar year 2012.				X
2. Continue implementation of adolescent immunization awareness media campaign.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During FY12 the Adolescent AFIX visits for the program evaluation project were completed. A total of 61 visits were conducted. Initial analysis of the data showed a significant increase in adolescent rates per practice following the AFIX intervention. The project looked at in-person AFIX visits and interactive webinar AFIX visits. Both methodologies showed significant increases in coverage rates. The effectiveness of the webinar visits may help the branch to increase the number of adolescent AFIX visits without overwhelming the staff or budget with additional travel time and expenses. The branch completed its contract with Better World Advertising to develop PSAs with messages to parents of adolescents about the immunizations their children need. PSAs were designed to target college students. In addition to the PSAs, the firm developed billboards, print graphics, and online (social media) advertisements for this target group. At the state immunization conference, IB staff members gave a presentation to attending provider staff on addressing and overcoming barriers to vaccinating adolescents. The IB continues to provide the resources/materials to schools to notify parents about the immunization requirements for sixth grade and college entry.

c. Plan for the Coming Year
During FY13, the number of adolescent AFIX visits will continue to increase as the effectiveness of webinar training has been established. Staff members have been encouraged by the CDC to present the results of the Adolescent AFIX program evaluation to colleagues at various national meetings in the coming year.

The branch will be conducting regional NCIR workshops on provider accountability. The branch retained ownership of all media items, including PSAs developed during FY12. If funding allows, the branch will launch another awareness campaign during FY13. The IB will continue to provide the resources/materials to schools to notify parents about the immunization requirements for sixth grade and college entry.

E. Health Status Indicators
For the majority of the Health Status Indicators (HSI), trend data show that there really is not a lot of movement up or down. One change worth noting is in HSI #7 -- Total Live Births by Race and Ethnicity. The number of births in North Carolina reached an all-time high of 130,886 resident births in 2007. Since then, however, there has been a steady decrease, with a fall of 6.5 percent in 2010 to 122,302 births, which mirrors national trends. There was a decrease in birth rates from 2007 to 2010 for women in all age groups except for those 40 years and older (increase of 5%). The largest decrease was among women ages 15-19. While fertility rates dropped for all race/ethnic groups, the largest decrease was among Hispanic/Latina women, falling nearly 42% from 2007 to 2010.

Also, the state's overall infant mortality rate for 2010 declined sharply, reaching its lowest level in state history. The rate, 7.0 infant deaths for every 1,000 live births, represents an 11.4 percent drop from the state's 2009 rate of 7.9 deaths. The largest decline was among African American infants, a reduction of 19.6 percent from the previous year. However, a racial disparity in infant mortality rates persists.

F. Other Program Activities
MCH Hotline - NC's Family Health Resource Line (1-800-FOR-BABY or 1-800-327-2229) has evolved from a prenatal care hotline to a multi-program resource. The hotline averages 3,500-4,000 calls a month and operates 24 hours a day, including holidays.

In 1990, North Carolina launched First Step, an infant mortality public awareness campaign, which included a statewide toll-free number. The line responded to calls related to preconceptional, prenatal, postpartum, and infant care; breastfeeding and nutrition; and Baby Love (Medicaid for pregnant women). In 1994, the Health Check Hotline (Medicaid for children) was launched. The line was co-located with the First Step Hotline, using the same staff but a separate toll-free number. With this expansion, the hotline's mission broadened to encompass child health topics. That same year, the First Step Hotline added a focus on prenatal substance use prevention and treatment. In 1998, programs pooled resources to create the NC Family Health Resource Line. The state's Smart Start Program, a public-private initiative that provides early education funding to all of the state's counties, became a partner and contributed early child development and parenting resources, and the Health Choice Program (SCHIP) marketed the line as their "call to action" to learn more about free and low-cost health insurance. In 2002, the NC Child Care Health and Safety Resource Center was merged into the NC Family Health Resource Line, again expanding breadth of services and resources. The NC Family Health Resource Line is funded by state dollars, federal Medicaid matching dollars and MCH grant funds.

In December 2009, the NC Family Health Resource Line became an automated system to triage calls and forward them to existing call centers based on the choices made by the caller. This change in service was prompted by a state budget crisis that required consolidation of existing hotline services. Calls relating to maternal and child health issues, family health, Health Check (Medicaid for Children), and NC Health Choice are routed directly to the CARE-LINE, NCDHHS's toll-free information and referral telephone service. Information and Referral Specialists provide information and referrals regarding human services in government and non-profit agencies. Currently, sixteen individuals staff the CARE-LINE. Of these staff, one specialist is the Office of Citizen Service's CARE-LINE Hispanic Citizen Services Representative and is dedicated to handling calls from Spanish-speaking customers. CARE-LINE staff members are well trained and have a wealth of knowledge regarding human service programs across North Carolina. Many staff persons are Certified Information and Referral Specialist by the National Alliance of Information and Referral Services. In FY 2009, these professionals provided information to more than 300,000 callers.

A second option in the NC Family Health Resource Line menu will direct families of CSHCN to the Title V CSHCN hotline which is operated (but not funded) by Title V.

Collaboration is a key strength of the NC Family Health Resource Line. The hotline is one of the few that has an advisory committee exclusively dedicated to oversight. Members of the committee include representatives from UNC-Chapel Hill, Title V, Medicaid, CSHCN, CARE-LINE, and other key stakeholders. With the hiring of a full-time parent liaison in the C&Y Branch and her work with the Family Council, the resource line has greater parental involvement.

In addition, the NCDHHS Office of Citizen Services that supports the CARE-LINE has also developed a website (NCcareLINK.gov) that provides up-to-date information about programs and services across North Carolina for families, seniors, youths and everyone in-between. It is a collaborative effort of NC DHHS and many other government and non-profit information and referral stakeholders across North Carolina.

Data Collection - Two major emerging issues on the horizon are in the area of data collection and comparability. In 2010, the NC State Center for Health Statistics plans to roll out the National 2003 birth certificate. This roll out will be in phases, and as a result, data compatibility for the calendar year of 2010 will be difficult. In addition to not being able to compare ourselves with all of the US because some states are using the old certificate, we will also not be able to compare ourselves backwards in all measures. Also, any data collected in 2010 will not be able to be compared within the year because part of the year will be the old certificate and some the new.

In addition the birth certificate, as mentioned in the data sources, North Carolina is in the process of implementing a new Health Information System (HIS) to replace the old Health Services Information System (HSIS). Statewide rollout is scheduled to take place from April to August 2010. This system will be used by all local health departments, directly or indirectly through batch reporting from another data collection system. Data comparability between the two systems might be a little problematic, but it is hoped that the requirement that the system replicate all functions of the old system will make those problems less severe. In addition all the old data will be ported over to the new HIS. HIS was developed using the Avatar PH off-the-shelf software with significant modifications. This should allow Program Staff and Managers to begin doing more in-depth evaluation because there will be more access to data previously uncollected or unavailable. In addition, improved data reporting functions as well as the ability to run reports on specific items of interest will help with evaluation. In the past, program managers have been stymied because of their inability to access data except through canned reports. The new system's capacity to run ad-hoc reports and to produce electronic reports is seen as a real benefit for evaluation and needs assessment.

/2012/ Due to budget cuts, on July 1, 2011, the CARE-LINE was shut down. The NC Family Health Resource Line still exists as an automated system to triage calls and forward them to existing call centers based on the choices made by the caller. Instead of being directed to the CARE-LINE, an additional option was created asking callers to call their local health department for information about items not already covered by other options that go to call centers (e.g., Health Check, Health Choice, CSHCN, and substance abuse). //2012//

/2013/The NC Family Health Resource Line is an automated system to triage calls and forward them to existing call centers based on the choices made by the caller. Instead of being directed to the CARE-LINE, an additional option was created asking callers to call their local health department for information about items not already covered by other options that go to call centers (e.g., Health Check, Health Choice, CSHCN, and substance abuse). Many parents and providers of CYSHCN have established a relationship with our FLS who staffs the toll-free CSHCN Help Line. These callers are now dialing directly into that number rather than through the NC Family Health Resource Line.//2013//

G. Technical Assistance

See Form 15 for specific technical assistance requests.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	16614558	16700327	16614558		16434955	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	50812077	39084076	38438685		37478306	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	65575818	58993104	65321573		65390524	
6. Program Income *(Line6, Form 2)*	102103953	57536376	96775698		57536376	
7. Subtotal	235106406	172313883	217150514		176840161	
8. Other Federal Funds *(Line10, Form 2)*	341710716	312525866	371599976		391516377	
9. Total *(Line11, Form 2)*	576817122	484839749	588750490		568356538	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	51860680	33906624	46125859		34797270	
b. Infants < 1 year old	25045543	19203297	23308138		19707723	

c. Children 1 to 22 years old	109120045	82262813	100384531		84423662	
d. Children with Special Healthcare Needs	25015256	16708189	22204682		17147074	
e. Others	23306956	19425993	24198697		19936268	
f. Administration	757926	806967	928607		828164	
g. SUBTOTAL	235106406	172313883	217150514		176840161	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	112760		103771		115500	
c. CISS	107142		148568		156458	
d. Abstinence Education	0		0		0	
e. Healthy Start	2621768		2697913		2493642	
f. EMSC	0		0		0	
g. WIC	220639460		252156714		259575021	
h. AIDS	40268		0		0	
i. CDC	12225834		8849983		11022369	
j. Education	0		0		0	
k. Home Visiting	0		0		2218502	
k. Other						
ACF	0		0		1545828	
CACFP	0		0		97108445	
CHIP	507380		575647		425491	
MCHB	1158757		607644		407209	
Medicaid FFP	2034819		1903651		2416447	
OAH	0		0		2458759	
SAMHSA	643034		1152578		847106	
SSBG	0		0		150000	
TANF	2950000		2950000		2950000	
Title X	0		0		7625600	
CACFP/SFP	90245482		90800729		0	
DHHS/OAH	0		1206923		0	
Title V Home Visit	0		454633		0	
Title X (FP)	8386233		7991222		0	
SAPT BG	37779		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	94899732	72479089	90459304		74382943	
II. Enabling Services	93439502	71560251	87395618		73439969	
III. Population-	35617454	18280986	30394222		18761185	

Based Services						
IV. Infrastructure Building Services	11149718	9993557	8901370		10256064	
V. Federal-State Title V Block Grant Partnership Total	235106406	172313883	217150514		176840161	

A. Expenditures

Total state partnership expenditures in 2009 were about $11.5 million over 2008. The primary reasons were due to increases in Medicaid expenditures for health services for women and children in local health departments and higher expenditures in the WIC program from formula rebates. These increases were probably due in part to a greater number of persons eligible for Medicaid and WIC services due to the economic downturn.

/2012/ Total state partnership expenditures in 2010 decreased by over $14 million from 2009. About $6 million of this amount was in lower Medicaid expenditures in local health departments for services to women and children. However, the majority of the reduction was attributed to reduced state expenditure for vaccine as the state reduced the budget for this item. //2012//

B. Budget

North Carolina's Maternal and Child Health Block Grant financial management plan assures the compliance with the Title V fiscal requirements.

Section 503 (a)
The state requires that all state match for the grant be budgeted in the same cost center with the relevant federal dollars. Upon expenditure of those pooled dollars, the state draws the appropriate number of federal dollars to reflect the 4:3 federal to state match rate.

Section 503 (c)
Administrative costs are identified in specific cost centers. Typically, these are costs that are charged in the division's cost allocation plan, and certain direct costs for administrative offices. Budgets for these cost centers are summed and compared to the total budget to assure they are not more than 10% of the total grant amount.

Section 505 (a) (3) (A & B)
The state budgets available funds in a series of cost centers called RCC's. These centers are used to group dollars intended for certain types of programs and services. The RCC's are assigned to one or both of the 30% "set aside" categories, and are assessed a percentage of the budget that can be attributable to services in the category. For example, the RCC 5745 consists of allocated funds to local health departments for child health services. We determine the proportion of the funds that are attributed to preventive and primary care service and services for children with special health care needs, then multiply the percentages by the allocation to come up with the respective amounts for each category. This assessment is performed for each RCC in which Title V funds are budgeted, and the sums for the two categories are compared to the total budget award to determine compliance.

Section 505 (a) (4)

The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH

programs as shown in Form 2 is $50,812,077. This includes state funds used for matching Title V funds, which for the FY11 application, is $12,462,372.

/2012/ Section 505 (a) (4)

The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $38,438,685. This includes state funds used for matching Title V funds, which for the FY12 application, is $12,462,372. //2012//

/2013/ Section 505 (a) (4) The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $37,478,306. This includes state funds used for matching Title V funds which, for the FY13 application, is $ 12,327,654.

In the FY 12-13 plan, there was a large difference noted in Form 3 between reported FY11 budget and expenditures in the Program Income line. In North Carolina, program income is defined as the amount of Medicaid payments to local public health departments (LHDs) for MCH-related services. The state has recently changed to a new information system through which LHDs bill for Medicaid reimbursable services, so different systems were used to generate the number for the budgeted amount and expended amount. When the large difference was noticed, an analysis was undertaken to determine the cause. It was found that the prior system was generating the amount that was billed to Medicaid, not paid. This inflated the amount reported as expended in a given year and therefore estimated as the budget for the subsequent year. The new system reported actual payments for FY11 and therefore is much lower. This amount is being used to estimate the budget for program income for FY 12-13. The budget for program income in the FY 11-12 application also reflected the falsely higher amount, and expenditures reported for that period will be lower in the FY 13-14 application. After that the comparison will be based on the same data source and will not show such a large discrepancy.

Because of this, the budget and expended amounts on forms 4 and 5 for each breakout also have variances that require an explanation, and the circumstances above are largely responsible for those variances. //2013//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.